



Student Wellness and Accessibility Centre

STUDENT HEALTH SERVICES	PERSONAL COUNSELLING SERVICES	STUDENT ACCESSIBILITY SERVICES	STUDENT HEALTH & WELLNESS HUB
T 905-688-5550 x3243 F 855-700-4793	T 1-833-276-2533 F 905-688-7260	T 905-688-5550 x3240 F 905-688-7260	T 905-688-5550 x5860

Student Accessibility Services Documentation Form

TO BE COMPLETED BY THE STUDENT

Dear Student,

The Student Wellness and Accessibility Centre uses this form to provide confirmation of disability and information regarding the impact on academic participation at Brock University. Information provided by your regulated health care provider, along with information provided by you, will assist in determining appropriate academic accommodations and supports in accordance with Ontario Human Rights Commission (OHRC) guidelines.

Documentation provided by students is confidential. Personal health information provided in this form is collected and used in accordance with Section 39(2) of the Freedom of Information and Protection of Privacy Act (FIPPA), 1990.

Please forward this document to a regulated health care provider who knows you well. The completed form can be uploaded with a New Student Registration or mailed, faxed or delivered in person to Student Accessibility Services at the above address. **Please note:** Medical professionals may charge a fee for completing this form.

A: Student Information

Last Name:	First Name:
Date of Birth:	Brock Student ID:

B: Consent for disclosure of diagnosis to SWAC

It is not mandatory that a diagnosis be disclosed in order to receive academic accommodations; however, consent may be requested if you apply for certain federally or provincially funded bursaries, grants, or external scholarships.

I have considered the risks and benefits, and:

- I consent to identification of a diagnosis on a voluntary basis to be included by my health care provider, OR;
- I do not consent to a diagnosis being included on this form.

C: Authorization for Release of Information

By signing below, I consent to allow the health care provider completing this form to provide information to the Brock University Student Wellness and Accessibility Centre concerning the specific purpose of identifying functional limitations to facilitate temporary or permanent accommodation in the academic environment. I understand that all information in this form will be treated in a highly confidential manner and only information regarding limitations and recommended accommodations will be shared outside of the Student Wellness and Accessibility Centre unless required by law. I agree that facsimile copies or photocopies of this form and any related documents will be considered as valid, original copies.

Student's Signature:	Date:
----------------------	-------



Brock University, Niagara Region
1812 Sir Isaac Brock Way, ST 400
St. Catharines, ON, Canada L2S 3A1
T 905-688-5550

Student Wellness and Accessibility Centre

STUDENT HEALTH SERVICES

T 905-688-5550 x3243
F 855-700-4793

PERSONAL COUNSELLING SERVICES

T 1-833-276-2533
F 905-688-7260

STUDENT ACCESSIBILITY SERVICES

T 905-688-5550 x3240
F 905-688-7260

STUDENT HEALTH & WELLNESS HUB

T 905-688-5550 x5860

Student Accessibility Services Documentation Form

TO BE COMPLETED BY THE REGULATED HEALTH PROFESSIONAL

Dear Health Care Professional,

Student Accessibility Services, within the Student Wellness and Accessibility Centre, is comprised of relevantly trained disability service professionals who work with students to determine appropriate resources, services, and academic accommodations. The information in this form will be used to assist in determining the most appropriate academic supports and accommodations based on individual functional limitations directly related to the student's permanent disability or temporary/cyclical health condition(s) according to the Ontario Human Rights Commission (OHRC) Policy on Ableism and Discrimination based on Disability, 2016, Section 8.7, "Medical Information to be Provided".

Documentation must be provided by a regulated health professional certified specifically in the area of disability or a treating physician who knows the patient well enough to comment on individualized functional limitations of the disability or condition.

Please complete all sections of this form as completely and objectively as possible based on a current assessment of function to ensure an accurate understanding of the request for accommodation and impact on participation in the academic environment. A statement of diagnosis is not mandatory to register with Student Accessibility Services or receive accommodation; however, a full and detailed description of functional impact is required to determine reasonable and appropriate academic accommodations. Please ensure the student has provided consent prior to completing this form. Your time and consideration is appreciated.

Please retain a copy for your records. The completed form can be sent **directly (preferable)** to:

Brock University
Student Wellness and Accessibility Centre
Student Accessibility Services
ST 400
1812 Sir Isaac Brock Way
St. Catharines, ON L2S 3A1
Fax: 905-688-7260
Phone: 905-688-5550 ext 3240
Email: askSAS@brocku.ca

Student Accessibility Services Documentation Form
TO BE COMPLETED BY THE REGULATED HEALTH PROFESSIONAL

Documentation of Disability:

For the purposes of this documentation, disability is defined as a significant functional limitation due to a health condition(s) that impairs the person's ability to perform daily activities necessary to participate in postsecondary studies.

Diagnosis (ONLY with patient consent. Provide DSM-V diagnosis, if applicable.):

Disability Type:

Providing information about disability type may influence eligibility for government funding in the academic environment. Please carefully consider prior to completion. Typically, designation of permanent disability is determined following assessment, treatment, and/or monitoring of patient for a significant amount of time or when combined with detailed chart review.

- Permanent disability defined by OSAP as "ongoing (chronic or episodic) symptoms that will restrict his/her ability to perform the daily activities necessary to fully participate in postsecondary studies or in the labour force, and the disability is expected to remain for his/her lifetime" (Ministry of Advanced Education and Skills Development, 2017).
- Temporary disability/medical condition: Accommodations recommended until (date): _____
- Updated documentation regarding functional status must be re-assessed due to the changing nature of the condition on (date): _____
- Student is being assessed to determine a diagnosis.
- No functional impact in the academic environment (i.e., current symptoms do not limit participation or student participates within functional limits with current treatment plan).

How long have you been treating this patient: _____

Date of diagnosis or reported onset: _____

Modes of Assessment:

Describe the method(s) of assessment (e.g., clinical interview, Connors, BRIEF, SCAT, GAD-7, PHQ-9, etc.):

If there are supporting documents available, please indicate and, with patient consent, attach a copy as appropriate.

- Psychoeducational Report (required for a student with a Learning Disability).
- Neurology/Neuropsychological Report
- Psychologist/Psychiatrist Assessment Report.
- Ophthalmologist/Optometrists Report.
- Audiologist Report.
- Rehabilitation Provider Report (e.g., physiotherapist, occupational therapist, speech language pathologist, social worker).
- Other: _____

Functional Impact in Academic Setting:

The below chart collects information regarding the functional impact of the condition or disability within the academic setting. This form is designed to apply to all domains; please respond only to applicable areas.

Please identify the degree of impact using the following scale:

- 1: Within Functional Limits or Not Applicable.
- 2: Mild Functional Impact or Slight Limitation.
- 3: Moderate Functional Impact.
- 4: Severe Functional Impact or Activity Restriction.
- U: Unknown; Unable to Comment.

Cognitive Skills/Abilities

<i>Cognitive Task</i>	<i>Degree of Impact Please circle.</i>	<i>Comment, if needed Duration, chronic/episodic, prognosis, observations.</i>
Sustain attention and concentration (for participation in academic tasks e.g., lectures, seminars, exams) for up to 3 hours or (time): _____	1 2 3 4 U	
Process and utilize written information for academic tasks	1 2 3 4 U	
Process and utilize verbal information for academic tasks	1 2 3 4 U	
Ability to complete multiple tasks within a short timeline (e.g., multiple assignments in 1 week; 2 exams in one day).	1 2 3 4 U	
Organize and manage time	1 2 3 4 U	
Organize and express ideas in a meaningful manner.	1 2 3 4 U	
Access short-term memory.	1 2 3 4 U	
Access long-term memory.	1 2 3 4 U	
Utilize working memory or divided attention (e.g., for note taking during lecture).	1 2 3 4 U	
Sustain cognitive effort for up to 3 hours or (time): _____	1 2 3 4 U	

Physical Skills/Abilities

<i>Physical Task</i>	<i>Degree of Impact Please circle.</i>	<i>Comment, if needed Duration, chronic/episodic, prognosis, observations.</i>
Ambulate/mobilize within academic environment (up to 1 km).	1 2 3 4 U	
Push/pull, reach, bend, lift, carry materials within the academic setting (e.g., lab supplies, backpacks, etc.).	1 2 3 4 U	
Maintain appropriate seated position (e.g., lectures, exams) for up to 3 hours <u>or</u> sit tolerance (time): _____	1 2 3 4 U	
Maintain appropriate sustained standing position for up to 3 hours (e.g., science lab) <u>or</u> stand tolerance (time): _____	1 2 3 4 U	
Produce legible written output for a period of up to 3 hours.	1 2 3 4 U	
Manipulate small objects in hands (e.g., lab materials).	1 2 3 4 U	
Sustain participation without increase in symptoms (e.g., fatigue, nausea, pain, headache, etc.).	1 2 3 4 U	
Sustain participation related to frequency or duration of washroom use .	1 2 3 4 U	
Sustain participation at specific times of day (describe):	1 2 3 4 U	
Other:	1 2 3 4 U	

Social/Emotional/Behavioural Functioning

<i>Social/Emotional/Behavioural Task</i>	<i>Degree of Impact Please circle.</i>	<i>Comment, if needed Duration, chronic/episodic, prognosis, observations.</i>
Participate in small group discussion within lecture/seminar.	1 2 3 4 U	
Participate in 1:1 discussion with instructor regarding course material or feedback.	1 2 3 4 U	
Communicate in writing with instructor/peers (e.g., email).	1 2 3 4 U	
Deliver oral presentations when prepared in advance.	1 2 3 4 U	
Communicate with peers to complete group work .	1 2 3 4 U	
Understand verbal and non-verbal social cues .	1 2 3 4 U	
Adapt to changes (e.g., room location, assignment deadline).	1 2 3 4 U	
Regulate emotions in assessment situations (e.g., tests or exams).	1 2 3 4 U	
Demonstrate insight into areas of difficulty and seek appropriate resources.	1 2 3 4 U	

<i>Social/Emotional/Behavioural Task</i>	<i>Degree of Impact</i> <i>Please circle.</i>	<i>Comment, if needed</i> <i>Duration, chronic/episodic, prognosis, observations.</i>
Regularly attend all classes. If limited, estimated percentage of absences/term based on past history: _____	1 2 3 4 U	
Regularly engage with course material (e.g., readings, assignments, labs, etc.). If limited, estimated percentage of days/term unable to participate based on past history: _____	1 2 3 4 U	
Other:	1 2 3 4 U	

Sensory Functioning

<i>Sensory Task</i>	<i>Degree of Impact</i> <i>Please circle.</i>	<i>Comment, if needed</i> <i>Duration, chronic/episodic, prognosis, observations.</i>
See lecture slides/presentations at the front of a lecture hall.	1 2 3 4 U	
See information on computer screen (e.g., email, research).	1 2 3 4 U	
See written material in regular size (i.e., 12-point font).	1 2 3 4 U	
Tolerate bright or florescent lighting.	1 2 3 4 U	
Tolerate scent in the environment.	1 2 3 4 U	
Tolerate loud or repetitive noises in the environment.	1 2 3 4 U	
Hear in a group setting with background noise (e.g., lecture, seminar).	1 2 3 4 U	
Participate in verbal conversation (hearing and/or speech).	1 2 3 4 U	
Process sensory information in the environment.	1 2 3 4 U	
Other:	1 2 3 4 U	

Vision

<i>Assessment</i>	<i>Degree of Impact</i> <i>Please circle.</i>	<i>Comment, if needed</i> <i>Duration, chronic/episodic, prognosis, observations.</i>
Left Eye (best corrected).	1 2 3 4 U	
Right Eye (best corrected).	1 2 3 4 U	
Both Eyes (best corrected).	1 2 3 4 U	
Other (e.g., colour blindness, convergence insufficiency, diplopia, etc.):	1 2 3 4 U	

Hearing

<i>Assessment</i>	<i>Degree of Impact</i> <i>Please circle.</i>	<i>Comment, if needed</i> <i>Duration, chronic/episodic, prognosis, observations.</i>
Left Ear (best corrected).	1 2 3 4 U	
Right Ear (best corrected).	1 2 3 4 U	
Both Ears (best corrected).	1 2 3 4 U	
Other (e.g., tinnitus, vertigo, etc.):	1 2 3 4 U	

Ongoing Support and Strategy Plan

Is the student under your active and continuous care? Yes No

Will you be providing care while the student attends university? Yes No

If no, is the student aware of supports needed and able to initiate access independently? Yes No

Is the student participating in ongoing treatment? Yes No

If yes, please provide a general overview of the components and estimated duration of the treatment plan (without reference to diagnosis):

Is an emergency medical plan required for this student? Yes No

If yes, please outline or attach recommended procedures or medical intervention plan (e.g., seizures, anaphylactic allergies, sudden onset mobility loss, etc.).

Do you consider this student to be in a stable condition and able to effectively manage the demands of academic life (workload, deadlines, attendance)? Yes No

Yes, with supports: _____

Is the student safe to work with vulnerable populations and to fulfil the work requirements of placement/co-op (i.e., full-time work load, participation, attendance, etc.)? Yes No

If no, please outline concerns: _____

Medication Information

Is the student currently taking medication(s) for symptoms? Yes No

If yes, is the medication likely to have an adverse effect on academic functioning? Please describe side effects, if appropriate:

Does the medication impact participation at a certain time of day? Yes No

If yes, please specify: Morning Afternoon Evening

Additional Information

Based on functional limitations, do you have any recommendations for specialized equipment or services?

Professional Information

Name of licensed medical professional (please print): _____

License/Registration #: _____

Area of Specialty/Title: _____

Signature: _____

Date: _____

Official Stamp:

Brock University protects your privacy and your personal information. The personal information requested on the form is collected under the authority of the Brock University Act, 1964, and in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA). Direct any questions about this collection to the Director of Student Wellness and Accessibility Centre at Brock University at 905-688-5550 ext. 3981.