

UCW Student Medical Documentation for Accessibility Services

Dear Health-Care Professional:

This patient is requesting disability-related academic supports and accommodations while studying at University Canada West in Vancouver, BC.

The purpose of this medical certificate is twofold:

1. Documentation assists the University in determining if a student is an individual with a disability who is eligible for service.
2. Documentation provides University personnel with the students' **restrictions and functional limitations** resulting from the disability, which will assist with the identification of appropriate academic accommodations and supports.

In order to consider the request, the student is required to provide the University with documentation which is:

- Completed by a licensed health-care professional, qualified in the appropriate specialty, and can diagnose disability within their scope of practice.
- Thorough enough to support the accommodations being considered or requested

Note: A diagnosis alone does not automatically mean disability-related accommodation is required

The provision of all reasonable accommodations and services is assessed based on the **current impact** of the disability on academic performance. Generally, this means that a diagnostic evaluation has been completed within the last year.

CONFIDENTIALITY

Collection, use and disclosure of this information is subject to all applicable privacy legislation

TO BE COMPLETED BY STUDENT

Student Number: _____

Student's Legal Name: _____

Date of Birth: ____/____/____(Year, Month, Day)

Email address: _____

Contact number: _____

RELEASE OF INFORMATION

I, _____, hereby authorize _____ to provide Accessibility Services at the University Canada West, Vancouver information regarding my disability(ies) including

- my diagnosis
- restrictions and limitations
- treatment
- accommodations
- other: _____

Student's Signature: _____ Date: _____

TO BE COMPLETED BY A CANADIAN HEALTH CARE PROFESSIONAL

Diagnosis and Concurrent Conditions

If the patient does not permit the disclosure of the diagnosis, please verify that a disability is present. There will be some instances where a diagnosis is required to establish eligibility for specific support (e.g., funding). **Please note any multiple diagnoses or concurrent conditions.**

Please note all applicable:

- Acquired Brain Injury/Concussion** Dx Onset _____
- Mental Health Disability** Dx (DSM V) (If the student permits please be specific e.g., Major Depressive Disorder – recurrent episode, Bi-Polar I Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, etc.)

How long have the symptoms presented (in months or years)? _____

- Medical** Dx: _____
- Hearing:** please attach a copy of the most recent audiogram

	Left Ear	Right Ear
Hearing loss (Specify type and severity)		
Tinnitus (please check):		
Other (please specify):		
Does the patient's hearing fluctuate? If so, please describe:		

- Vision** Dx: _____

	Visual Acuity	Visual Acuity –Best Corrected	Visual Field	Visual Field – Best Corrected
OD				
OS				
OU				
Other comments on diagnosis (e.g., night vision, depth perception, ocular mobility/balance, colour perception, constriction, etc.):				

- Other** Dx: _____
- I am in the process of monitoring and assessing the student's health condition to determine a diagnosis and this assessment is likely to be completed by _____. (Note: Updated documentation will be required to continue to provide academic accommodations).

STATEMENT OF DISABILITY

Characteristics of Condition(s): Continuous Episodic/Recurrent

Expected Duration:

- Temporary** with anticipated duration from ____/____/____ to ____/____/____ (Year, Month, Day)
- If duration unknown, please indicate reasonable duration for which the patient should be accommodated/supported (please specify): ____ (number of weeks, months)
- Permanent** disability with on-going (chronic or episodic) symptoms (that will impact the student over the course of his/her academic career and is expected to remain for his/her natural life).

- Must be reassessed every _____ due to the changing nature of the illness or requires follow up for monitoring

TO BE COMPLETED BY A CANADIAN HEALTH CARE PROFESSIONAL

Restrictions and Limitations

What are the restrictions and impacts/functional limitations on the patient's daily life and academic functioning?

IMPORTANT NOTICE:
As this certificate covers the impact of all types of disabilities there are questions that may not be relevant to your patient. Check only the areas that apply.

Where noted, please indicate the severity of disability based on number of symptoms, severity of symptoms and functional impact in an academic environment.

- Mild:** The student should be able to cope with minimal support. Functional limitation evident in this area.
Moderate: The student requires some degree of academic accommodations, as symptoms are more prominent.
Severe: The student has a high degree of impairment with significant academic accommodations required as symptoms and impact markedly interfere with academic functioning.

VISION	Comments/Recommendations to manage impact/ What alleviates symptoms?
<ul style="list-style-type: none"> • Eye fatigue/strain after _____ minutes • Other (please specify): 	
HEADACHES/MIGRAINES	Comments/Recommendations to manage impact/ What alleviates symptoms?
<input type="checkbox"/> Headaches <input type="checkbox"/> Migraines Triggers and impact of headache/migraine: Frequency of headache/migraine:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Can range mild-severe
SEIZURE DISORDER	Comments/Recommendations to manage impact/ What alleviates symptoms?
<input type="checkbox"/> Type(s): _____ <input type="checkbox"/> Restrictions: _____	<input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Triggers: _____ Recommended response in the event a seizure occurs at school:
SLEEP CYCLES & ENERGY	Comments/Recommendations to manage impact/ What alleviates symptoms?
<input type="checkbox"/> Fatigue <ul style="list-style-type: none"> ○ Temporary due to medication side effects. Expected duration: _____ ○ Fluctuating energy 	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Sleep disorder or difficulties _____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

<p>*Note: Students are encouraged to create healthy sleep habits and to discuss this with their health-care practitioner so as to minimize the impact at school</p>	<p>Impact on academic activities: _____</p>
<p>PHYSICAL</p>	<p>Comments/Recommendations to manage impact/ What alleviates symptoms?</p>
<p>Ambulation</p> <p><input type="checkbox"/> Activity as tolerated</p> <p>Restrictions:</p> <p><input type="checkbox"/> Short distance only</p> <p><input type="checkbox"/> Other (e.g., uneven ground): _____</p>	
<p>Standing (e.g., sustained standing in laboratory)</p> <p><input type="checkbox"/> Activity as tolerated</p> <p>Restrictions:</p> <p style="padding-left: 20px;"><input type="checkbox"/> No prolonged standing specify ___ mins.</p> <p><input type="checkbox"/> Loss of balance</p> <p><input type="checkbox"/> Other: _____</p>	
<p>Sitting for sustained period of time (e.g., in lecture or exam)</p> <p><input type="checkbox"/> Activity as tolerated</p> <p>Restrictions:</p> <p style="padding-left: 20px;"><input type="checkbox"/> No prolonged sitting specify ___ mins.</p> <p><input type="checkbox"/> Other: _____</p>	
<p>Stair climbing</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Activity as tolerated</p> <p><input type="checkbox"/> Other: _____</p>	
<p>Lifting/Carrying/Reaching</p> <p><input type="checkbox"/> Advised not to carry/lift more than: _____ lbs</p> <p><input type="checkbox"/> Limited reaching, pushing, pulling</p> <p><input type="checkbox"/> Limited range of motion (please specify): _____</p> <p><input type="checkbox"/> Other: _____</p>	
<p>Grasping/gripping</p> <p><input type="checkbox"/> Dominant hand (please circle): Left <input type="checkbox"/> Right <input type="checkbox"/></p> <p><input type="checkbox"/> Minimize repetitive use</p> <p><input type="checkbox"/> Limited dexterity (please specify): _____</p>	
<p>Neck</p> <p><input type="checkbox"/> No prolonged neck flexion</p> <p><input type="checkbox"/> Reduced range of motion</p> <p><input type="checkbox"/> Other: _____</p>	
<p>Pain</p> <p><input type="checkbox"/> Chronic</p> <p><input type="checkbox"/> Episodic</p>	<p><input type="checkbox"/> Mild</p> <p><input type="checkbox"/> Moderate</p> <p><input type="checkbox"/> Severe</p> <p><input type="checkbox"/> Can range mild-severe _____</p> <p>Impact on academic functioning: _____</p>
<p>Skin</p> <p><input type="checkbox"/> Avoid contact with _____</p> <p><input type="checkbox"/> Other: _____</p>	
<p>Bowel and Urinary</p> <p><input type="checkbox"/> Frequent (which may impact academic activities such as writing an exam)</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Mild</p> <p><input type="checkbox"/> Moderate</p> <p><input type="checkbox"/> Severe</p>

Stamina <input type="checkbox"/> Reduced Stamina Frequency of rest breaks (e.g., min. per hour)	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
COGNITIVE	Comments/Recommendations to manage impact/ What alleviates symptoms?
<input type="checkbox"/> Cognitive fatigue requiring rest due to acquired brain injury (including concussion) <input type="checkbox"/> Student advised to withdraw from school activities until effects of injury subside Date recommended to return to studies:	
<input type="checkbox"/> Distractibility	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Diminished ability to think or concentrate	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Memory deficit (e.g., head injury, learning disability) <ul style="list-style-type: none"> ○ Short term (e.g., 30 seconds such as following direction) ○ Long term (ability to retrieve and recall information stored) 	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Concentration difficulties <input type="checkbox"/> Concentration impacts memory	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Information processing (written and verbal) impaired	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Difficulty with organization and time management	
<input type="checkbox"/> Low motivation	
<input type="checkbox"/> Executive functioning (ability to multi-task, prioritize, etc.)	
<input type="checkbox"/> Difficulty staying on and completing tasks	
<input type="checkbox"/> Judgement (anticipating the impact of one's behaviour on self and others)]	
<input type="checkbox"/> Other impact and restrictions:	
STRESS MANAGEMENT	Comments/Recommendations to manage impact/ What alleviates symptoms?
<input type="checkbox"/> Difficulty with high pressure situations (e.g., managing multiple deadlines, multiple exams, heavy workload)	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Easily overwhelmed and response to stress is out of proportion to situation	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Emotional irritability	
<input type="checkbox"/> Other impact and restrictions:	
COMMUNICATION AND SOCIAL	Comments/Recommendations to manage impact/ What alleviates symptoms?

<input type="checkbox"/> Deficits in oral communication for social purposes (e.g., saying hello)	
<input type="checkbox"/> Significant difficulty in social participation (This may cause difficulties with participating in class and group settings)	
<input type="checkbox"/> Significant difficulty related to speaking in public or presentations	
<input type="checkbox"/> Difficulty understanding what is not explicitly stated (e.g., do not pick up on metaphors, humour, etc.)	
<input type="checkbox"/> Difficulty controlling emotions when overwhelmed	
<input type="checkbox"/> Other impact and restrictions:	
HEALTH & SAFETY	Comments
<input type="checkbox"/> Must not operate machinery	
<input type="checkbox"/> Must not handle dangerous chemicals	
<input type="checkbox"/> Student has a condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork, (e.g., seizure disorder, severe allergic reaction)	If "yes", please describe condition(s) and recommended response Comments:
<input type="checkbox"/> Other (please specify):	

CURRENT TREATMENT PLAN AND GOALS

- Physiotherapy_____
- Counselling_____
- Referred to specialist - type of specialist:_____

Medication(s) which may impact academic performance			
Adverse effect(s) which may impact academic performance	If applicable, when are adverse or side-effects likely to negatively affect their academic functioning? (Check all that apply):		Please note if the student is currently undergoing a change in medication (type/dose), how may that impact academic performance and length of time before effects felt
	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	

CLINICAL METHODS TO DIAGNOSE DISABILITY AND IDENTIFY FUNCTIONAL LIMITATIONS

- Diagnostic Imaging/Tests (please check): MRI CT EEG X-ray
- Neuropsychological Assessment (please provide a copy of the report)
- Psychiatric Evaluation Dates:_____
- Psycho-educational Assessment (please provide a copy of the assessment)
 - If ADHD, indicate assessment tools utilized for diagnosis:_____
- Writing Aids Assessment (please provide a copy of the assessment)

- Behavioural observations
- Other: _____

SUPPORTS RECOMMENDED AT UNIVERSITY

- The patient has been advised to reduce his/her course load** _____
- Accommodations may need to be considered as the patient was unable to attend school from _____ - _____ until _____.
- Service animal (e.g., autism support, guide dog, seeing eye dog, psychiatric service dog, mobility support animal, seizure alert animal) Type of animal: _____
 - Rationale (what restrictions and limitations result in the need for a support animal?): _____
- Accessible parking space
- Other: _____

BACKGROUND AND FOLLOW UP

If Motor Vehicle Accident: Date of Accident _____/_____/_____

How long have you been treating this patient? _____

Last date of Clinical Assessment: _____

Next appointment: _____

Other Comments (e.g., student strengths): _____

HEALTH CARE PRACTITIONER INFORMATION		
Name of Health Practitioner (please PRINT):		
Facility Name and address - Please use office stamp Note: If you do not have an office stamp please sign and attach your letterhead – signatures on prescription pads will NOT be accepted	Specialty: <input type="checkbox"/> Audiologist <input type="checkbox"/> Chiropractor <input type="checkbox"/> Family Medicine <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Neurologist <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Optometrist	<input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other: _____
Health Practitioner Signature:		Registration No.
Date:	Telephone No.	Fax No.