Dear Health Care Professional,

You have been asked to complete this form by a student who wishes to register with Student Success Services (SSS) at Canadore College. SSS provides academic accommodations and educational support services for students with documented disabilities attending Canadore College. Our goal is to provide the necessary accommodations to equalize the opportunity for students to meet their essential course or program requirements while maintaining academic integrity. We are mandated by the Human Rights Commission’s Guidelines for Accommodating Persons with Disabilities, the Ontario Human Rights Code and Canadore College Policies.

The purpose of this form is to provide a system-wide approach for Regulated Health Care Professionals to document the functional limitations that a student with a disability is likely to experience at college. **We rely on your knowledge of this student’s disability, including a description of the current functional impairments that may impact his/her ability to meet essential course or program requirements and to determine appropriate academic accommodations**.

As you know, the post-secondary environment involves taking examinations, doing research, completing assignments, and assuming responsibility for one’s higher education pursuits. The information you have provided should clearly relate to accommodation planning for studies at the post-secondary level.

Under the Ontario *Human Rights Code*, it is not a requirement to provide a **specific diagnosis** to access accommodations and support services from SSS. Disclosure of a diagnosis may be required for some government financial aid programs for students with disabilities. Students are asked to indicate if they provide consent to release this information on **page one** of this document.

*Thank you*

**Medical Information Request Form**

***This form will be used as one of the criteria to determine eligibility for academic accommodations and support services at Canadore College. All information received will be kept strictly confidential and does not impact admission decisions****.*

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| **SECTION A: To be completed by student** |

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B**.: (DD/MM/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Campus**: [ ] Education Centre [ ] Commerce Court [ ] Aviation [ ] Parry Sound [ ] On-Line

**Student consent to release of information pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the health care professional to provide the following information to Student Success Services (SSS) at Canadore College. Under the Ontario *Human Rights Code*, it is not a requirement to provide a **specific diagnosis** to access academic accommodations and services from the SSS.

**Please note:**

A diagnosis is required to access some government financial aid programs for students with disabilities.

If you wish to access such funding, you need to provide consent for the diagnosis information to be released.

**Check one:**

[ ]  I give consent for a diagnosis to be provided

[ ]  I do not give consent for a diagnosis to be provided

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature Date

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| **SECTION B: To be completed by Regulated Health Care Professional** |

The following criteria must be met when determining a disability.

1. The student experiences functional limitation(s)
2. The functional limitation(s) impairs the student’s academic functioning at the post-secondary level

**Select the appropriate option:**

[ ] 1. This student has a **permanent** disability with symptoms that are [ ] continuous OR [ ] episodic

[ ] 2. This student has a **temporary** disability with symptoms that are [ ] continuous OR [ ] episodic

Interim academic accommodations to be provided until (date)\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Updated documentation required after this date*

**Medications:** Has the student been prescribed medication that may impact academic functioning? [ ] Yes [ ] No

If yes, describe impact:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The student has the following **Diagnosis: (\*when consent given on page 1)**.

When applicable, use DSM-5 criteria.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Impact of disability: check appropriate boxes below to indicate impact on academics** |
| **Skills/Abilities** | **No Impact** | **Mild Impact** | **Moderate Impact** | **Severe Impact** | **Not assessed** |
| **COGNITION**  |
| Attention / Concentration |  |  |  |  |  |
| Long-term Memory |  |  |  |  |  |
| Short-term Memory |  |  |  |  |  |
| Executive Functioning |  |  |  |  |  |
| Information Processing |  |  |  |  |  |
| Managing distractions (filter out stimuli) |  |  |  |  |  |
| **PHYSICAL** |
| Mobility |  |  |  |  |  |
| Gross motor |  |  |  |  |  |
| Fine motor |  |  |  |  |  |
| Ability to sit for a sustained period of time |  |  |  |  |  |
| Ability to stand for a sustained period of time |  |  |  |  |  |
| **SENSORY** |
| Vision (with correction): Describe below |  |  |  |  |  |
| Hearing (with correction): Describe below |  |  |  |  |  |
| Speech: Describe below |  |  |  |  |  |
| **SOCIAL / EMOTIONAL** |
| In-class and group work interactions |  |  |  |  |  |
| Ability to perform class presentations |  |  |  |  |  |
| **OTHER: (state)** |
|  |  |  |  |  |  |
| **Please provide any recommendations or further elaboration:** |
| **SECTION C: Certification of Regulated Health Care Professional** |

**Please print**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am a legally qualified health care professional and this report contains my findings and considered opinion at this time, within my scope of practice.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Licence/Registration Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Care Profession:**

[ ]  Physician – Family [ ]  Physician – Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Psychologist / Psychological Associate

**Medical Office Stamp:**

|  |  |
| --- | --- |
|  | **Completed forms may be forwarded to:**Student Success ServicesCanadore College100 College Drive, ON P1B 8K9Fax: 705-495-2862Tel: 705-474-7600 x 5205 |

|  |  |  |
| --- | --- | --- |
| From: | Student Success ServicesCanadore College | **FAX** |
| Fax: | 705-495-2862 |
| Phone: | 705-474-7600 x5205 |

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| --- | --- |
| To: |  |
| Fax: |  |
| Phone: |  |
| Pages: |  |
| Re: | Medical Information Request Form |

**CONFIDENTIAL**

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| Notes: |