

Accessible Learning Centre

BRAIN INJURY: Disability Verification

This form should be completed by one of the following appropriately licensed and trained Health Care Professionals (HCP):

Neurologist, Neuropsychologist, Family Physician or Sports Medicine Physician.

SECTION A: TO BE COMPLETED BY STUDENT

Please print clearly in black or blue ink

STUDENT INFORMATION:

Last Name: _____ Preferred/Given Name: _____
 Date of Birth: _____ Student Number: _____
 Phone: _____ Laurier Email: _____@mylaurier.ca

ABOUT THIS FORM:

The Accessible Learning Centre (ALC) requires confirmation of the student's presenting diagnosis and disability status. Information about how the disability condition impacts the student's access to the academic environment is used as a part of the ALC assessment to determine eligibility for academic accommodations in the post-secondary environment. ALC will also use this information to determine eligibility for disability related services and/or equipment while attending Wilfrid Laurier University. Note: The student may be required to provide an updated assessment using this form should the nature and severity of the condition change and require additional accommodation supports.

CONFIDENTIALITY:

Information provided to ALC is kept **strictly confidential** and will not be shared with anyone outside of ALC. Information will not be released without the expressed written consent of the student.

ACADEMIC ACCOMMODATION & ACCOMMODATION PLANNING:

The information provided in this form will be used to determine eligibility for academic accommodation.

STUDENT DECLARATION:

Documentation completed by a relative of a student will not be accepted due to professional and ethical considerations, even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions in Section B of the form below.

I confirm that the individual completing Section B of this verification form is **not** a relative of mine. YES NO

CONTACT WITH MY HEALTH CARE PROFESSIONAL:

I give consent for ALC to contact my HCP to discuss information provided in this document, if necessary, to a) clarify information regarding my functional limitations and/or; b) obtain information for provision of academic accommodations at Wilfrid Laurier University. YES NO

RELEASE OF INFORMATION:

I hereby authorize my HCP, who is completing and signing this form, to share information with Laurier's ALC about my disability and its functional impacts. By signing this form, I certify that the information provided is true.

Misrepresentation of facts in connection with this form may be sufficient cause, in and of itself, for suspension of access to academic accommodations whenever discovered.

Student Signature: _____

Date: _____

Student's Informed Release is done in accordance with the following sections of the Freedom of Information and Protection of Privacy Act: 41.(1) (a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), 42 (1)(c), and 42(1)(d) allowing for the disclosure of personal information.

SECTION B: TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Please print clearly in black or blue ink

HEALTH CARE PROFESSIONAL (HCP):

Accessible Learning Centre (ALC) relies on your detailed knowledge of this student's disability, especially how its **limitations or restrictions may impact their learning and participation** in post-secondary education. Careful consideration should be given to the **verification of disability** and **degree of functional limitation** in the sections below.

Documentation completed by a relative of the student will not be accepted due to professional and ethical considerations, even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form below.

In order to complete the questions below, I am basing my responses on:

- An assessment I completed with the student.
- A previous assessment completed by _____ (health care professional's name), on _____ (date).

VERIFICATION OF DISABILITY:

Disability is defined as a functional limitation due to the disorder that restricts the student's ability to perform daily activities necessary to participate in post-secondary studies **Please verify disability status by initialing in the appropriate box below:**

- I confirm that this student **has a disability** according to the criteria outlined above.
- Pending: I am **in the process of monitoring and assessing** the student's condition.
- I confirm that this student **does not present with a disability** according to the criteria outlined above.

VERIFICATION OF DIAGNOSIS:

Please provide a clear diagnostic statement. (Avoid phrases 'suggests', 'is indicative of', etc.) **NOTE:** Indicate any co-existing conditions.

Primary: _____ **Date:** _____

Secondary: _____ **Date:** _____

Additional information:

DURATION OF DISABILITY CONDITION: (Please initial in the appropriate box below)

- PERMANENT:** Ongoing and continuous, will impact the student over the course of their academic career, *and* is expected to remain for their natural life.
- PERMANENT, EPISODIC:** Periods of good health interrupted by periods of illness or disability and is expected to remain for their natural life.
- TEMPORARY*:** Condition is not expected to be pervasive, continuous or recurrent/episodic in nature.

Accessible Learning Centre

BRAIN INJURY DISABILITY VERIFICATION FORM

PROVISIONAL*: I am still assessing the student.

*Please indicate a **reasonable duration** for which the student should be accommodated:
_____ (number of months)

CLINICAL ASSESSMENT METHODS USED: (Check all that Apply)

Note: please provide a copy of most recent assessment including scores (if possible).

- | | |
|---|-------------|
| <input type="checkbox"/> Clinical/Physical Examination | Date: _____ |
| <input type="checkbox"/> Formal /Diagnostic Assessment Scales | Date: _____ |
| <input type="checkbox"/> Disability Assessment Scales | Date: _____ |
| <input type="checkbox"/> Clinical Interview/Behavioural Observation | Date: _____ |
| <input type="checkbox"/> Other _____ | Date: _____ |

DISABILITY INFORMATION:

Describe/List the type of injury: _____

Date of Injury: _____

Severity of Injury: Mild Moderate Severe

Has the student had previous concussions? YES NO

If yes, please indicate how many: _____

Has the student been hospitalized for treatment of this condition? YES NO

If yes, provide date of the most recent hospitalization: _____

Is the student's functioning restricted at certain times of the day? If so, please specify:
 Morning Afternoon Evening

Is the student's sleep impacted by this condition? YES NO

If yes, please specify: _____

Does the student experience sensitivity to light? YES NO

If yes, please specify: _____

Does the student experience sensitivity to noise? YES NO

If yes, please specify: _____

Does the student experience eye fatigue/strain? YES NO

If yes, please specify: _____

Accessible Learning Centre

BRAIN INJURY DISABILITY VERIFICATION FORM

Does the student have restricted ability to view screens?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please specify: _____		
Does the student have restricted ability to read print (paper)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please specify: _____		
Does the student have visual/perceptual problems?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please indicate: _____		

DISABILITY AIDS/SUPPORTS:	
<input type="checkbox"/> Walker	<input type="checkbox"/> Cane/Crutches/Walking Stick
<input type="checkbox"/> Ergonomic Chair/Desk	<input type="checkbox"/> Arm Brace/Cast
<input type="checkbox"/> Leg Brace/Cast	<input type="checkbox"/> Other: _____

FUNCTIONAL LIMITATIONS/IMPACTS:
<p>In the following section, please check the severity of disability based on the <i>number of symptoms/restrictions, severity of symptoms/restrictions, and their impact on the student's functioning</i> in a university academic environment.</p> <p>No Limitation: The student does not require academic accommodation.</p> <p>Mild: The student should be able to cope with minimal support.</p> <p>Moderate: The student requires academic accommodation, as symptoms are more prominent.</p> <p>Severe: The student requires significant academic accommodation, as symptoms highly interfere with academic functioning.</p> <p>Unknown: Unknown or unable to assess at this time.</p>

PHYSICAL:					
<i>Symptoms/Limitations</i>	<i>No Limitation</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Unknown</i>
Headache					
Fatigue/Drowsiness					
Vomiting					
Nausea/Dizziness					
Balance Problems					
Seizures (indicate frequency: _____)					

THINKING:					
<i>Symptoms/Limitations</i>	<i>No Limitation</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Unknown</i>
Feeling mentally foggy					
Feeling Slowed Down					
Concentration (long period more than 30 minutes)					
Concentration (short period less than 10 minutes)					

Accessible Learning Centre

BRAIN INJURY DISABILITY VERIFICATION FORM

SOCIO-EMOTIONAL:					
Symptoms/Limitations	No Limitation	Mild	Moderate	Severe	Unknown
Mood Irritability					
Sadness					
Low Motivation					
Nervousness					
Difficulty Managing Academic Stressors					
Difficulty Managing Internal Distractions					
Difficulty Managing External Distractions					
Difficulty Making Decisions					
Comments:					

ACTIVITIES:					
Using the same scale above, please indicate the level of impact of the student's disability and their associated symptoms/restrictions on the following activities expected of them in a university environment:					
Activity	No Limitation	Mild	Moderate	Severe	Unknown
Attending Class					
Participating in Class					
Participating in Group Projects					
Delivering Presentation					
Taking Notes					
Reading					
Writing					
Completing Exams					
Time Management					
Organization					
Planning					
Managing Multiple Academic Demands					
Managing Competing Deadlines					
Information Processing (verbal)					
Information Processing (reading)					

Accessible Learning Centre

BRAIN INJURY DISABILITY VERIFICATION FORM

Information Processing (writing)					
Other (please describe):					

REDUCED COURSE LOAD (as a REQUIRED academic accommodation):

Does the nature and severity of the student's disability limit participation in:

Activities of daily living?

YES

NO

The academic environment?

YES

NO

Does the nature and severity of the student's disability make the student unable to meet the demands of a full course load (15-20 hours of class, lab, or tutorial meetings per week, plus 25-30 hours of study time per week, depending upon the program)?

YES

NO

Does the nature and severity of the student's disability **require** a reduced course load to mitigate the symptoms of the condition?

YES

NO

If yes, please estimate the **maximum** amount of time in hours per week that the student should be able to spend in these activities: _____

Will the reduced course load be required for the whole duration of the academic program to mitigate symptoms of the condition (for permanent and episodic conditions only)?

YES

NO

NEED FOR SERVICE ANIMALS (as an academic accommodation):

Please note that Accessible Learning does not provide access to service animals. Obtaining a trained service animal is the responsibility of the student. A service animal agreement, confirming handler responsibilities must be completed by the student.

I am making a recommendation for a service animal as a **required** accommodation to support to the student's participation in post-secondary education

YES

NO

This recommendation for diagnosis/treatment is consistent with my scope of practice as defined by my professional licencing body/regulatory college. I am legally permitted to make this recommendation in my jurisdiction of practice.

YES

NO

Please confirm type of animal: _____

Service animals are working animals. Please indicate the functions the service animal will provide at post-secondary:

- Reminding student to take their medication
- Symptom management
- Supporting student with classroom attendance
- Supporting student in examination situations
- Supporting student with campus navigation
- Other identified tasks (please indicate): _____

CURRENT MANAGEMENT: (Check all that Apply)

- | | |
|--|---|
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Speech/Language Therapy | <input type="checkbox"/> Chiropractic Therapy |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Counselling |
| <input type="checkbox"/> Other: _____ | |

Is the student currently taking medication for their symptoms? YES NO

If yes, please specify any side effects that impacts the student's functioning:

ADDITIONAL INFORMATION:
 Please use this space to provide any other information about the student's disability and their functional limitations that Laurier should consider in supporting the student.

HEALTH CARE PROFESSIONAL INFORMATION:

Name:
 (Please PRINT)

Facility Name and Address (Please use Official Stamp)
 (Note: If you do not have an office stamp, please sign, date, and attach a page of your Office Letterhead)

	Specialty:	
	<input type="checkbox"/> Neuropsychologist	<input type="checkbox"/> Neurologist
	<input type="checkbox"/> Family Physician	<input type="checkbox"/> Sports Medicine Physician

Health Care Professional Signature:

Registration/License No.:

Date:

Phone:

Fax:

Accessible Learning Centre

BRAIN INJURY DISABILITY VERIFICATION FORM

How to Submit Form:

This document, once completed by your Health Care Practitioner, should be uploaded with your online student application on [Accessible Learning Online](#) . If you are unable to upload your documentation, you can submit it to Accessible Learning Centre in person, by mail or fax:

Waterloo Campus

P220, 2nd Floor, Peters Building

75 University Avenue West

Waterloo, ON, N2L 3C5

Phone: 519-884-0710 x3086

Email: accessible_learning@wlu.ca

Fax: 519-884-6570

Brantford Campus

One Market, OM 207-20

73 George Street

Brantford, ON, N3T 2Y3

Phone: 519-756-8228 x5871

Email: lbaccessiblelearning@wlu.ca

Fax: 519-884-6570

Please note that the Accessible Learning Centre will review the submitted application and contact the student within 5-10 business days to begin the registration process.

Updated August 27, 2020.