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Accessible Learning

BRAIN INJURY: Disability Verification

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

Family Physician, Neurologist, Neuropsychologist, Nurse Practitioner, 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:

Accessible Learning requires confirmation of the student's presenting diagnosis and disability status. Information about how the disability condition impacts the student's access the academic environment is used as a part of the Accessible Learning assessment to determine eligibility for academic accommodations in the post-secondary environment. Accessible Learning 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 Accessible Learning is kept ***strictly confidential*** and will not be shared with anyone outside of Accessible Learning. 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 Accessible Learning 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 Accessible Learning 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 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 expected life.
☐ **PERMANENT, EPISODIC:**	Periods of good health interrupted by periods of illness or disability and is expected to remain for their natural life.
☐ **PERSISTENT OR PROLONGED:** **Condition expected to last _____ months**	Ongoing and continuous, will impact the student over the course of their academic career *and* is expected to last at least 12 months, *and* is not a permanent disability.

☐ **TEMPORARY:** **Condition expected to last _____ months**	Condition is not expected to be pervasive, continuous or recurrent/episodic in nature, *and* is expected to last no more than 12 months.
☐ **PROVISIONAL:** **Assessment expected to take _____ months**	I am still assessing the student.

CLINICAL ASSESSMENT METHODS USED: (Check all that Apply)

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

☐ Clinical/Physical Examination Date: _____

☐ Formal /Diagnostic Assessment Scales Date: _____

☐ Disability Assessment Scales Date: _____

☐ Clinical Interview/Behavioural Observation Date: _____

☐ 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: _____		
Does the student have restricted ability to view screens?	☐ YES	☐ NO
If yes, please specify: _____		
Does the student have restricted ability to read print (paper)?	☐ YES	☐ NO
If yes, please specify: _____		
Does the student have visual/perceptual problems?	☐ YES	☐ NO
If yes, please indicate: _____		

DISABILITY AIDS/SUPPORTS:

☐ Walker	☐ Cane/Crutches/Walking Stick
☐ Ergonomic Chair/Desk	☐ Arm Brace/Cast
☐ Leg Brace/Cast	☐ Other: _____

FUNCTIONAL LIMITATIONS/IMPACTS:

In the following section, please check the severity of disability based on the *number of symptoms/restrictions*, *severity of symptoms/restrictions*, and their *impact on the student's functioning* in a university academic environment.

***No Limitation*:** Student does not require academic accommodation.
***Mild*:** Student should be able to cope with minimal support.
***Moderate*:** Student requires academic accommodation, as symptoms are more prominent.
***Severe*:** Student requires significant academic accommodation; symptoms highly interfere with academic functioning.
Unknown: Unknown or unable to assess at this time.

PHYSICAL:

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

THINKING:

Symptoms/Limitations	***No Limitation***	***Mild***	***Moderate***	***Severe***	***Unknown***
Feeling mentally foggy					
Feeling Slowed Down					

Concentration (long period more than 30 minutes)					
Concentration (short period less than 10 minutes)					
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)					
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 **require** a reduced course load to mitigate the symptoms of the condition? ☐ YES ☐ NO

A full course load is 15-20 hours of class, lab, or tutorial meetings per week, plus 25-30 hours of study time per week, depending upon the program

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, episodic, or persistent/prolonged conditions only)? ☐ YES ☐ NO

CURRENT MANAGEMENT: (Check all that Apply)

☐ Physiotherapy ☐ Occupational Therapy

☐ Speech/Language Therapy ☐ Chiropractic Therapy

☐ Massage Therapy ☐ Counselling

☐ 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:	
	☐ **Family Physician**	☐ **Neurologist**
	☐ **Neuropsychologist**	☐ **Nurse Practitioner**
	☐ **Sports Medicine Physician**	
Health Care Professional Signature:	**Registration/License No.:**	
Date:	**Phone:**	

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* . Visit *Accessible Learning* for uploading instructions or contact us at accessible_learning@wlu.ca Please note that Accessible Learning will review the submitted application and contact the student within 5-10 business days to begin the registration process.

Updated July, 2023.