



Brain Injury Disability Verification

Section A: To be Completed by the Student

Student Information

Last Name: Preferred / Given Name:
Date of Birth: Phone Number:
Student Number: Laurier Email:

About this Form

Accessible Learning uses the information collected in this form to determine eligibility for academic accommodations, bursaries, and other supports at Wilfrid Laurier University. The purpose of this form is to (a) confirm that you are a person with a disability and (b) obtain information about the functional limitations stemming from your disability and their impact on your access to the learning environment.

Personal information is collected under the authority of the Wilfrid Laurier University Act and privacy policies to administer the university-student relationship. For more information about how your information is used, collected and shared, please visit wlu.ca/privacy.

Disclosure of Diagnosis and Release of Information

You are not required to disclose your medical diagnosis to receive academic accommodations and supports. You are required to confirm the nature of your disability and provide information about your disability-related functional limitations.

I give my consent for my health care provider to disclose my medical diagnosis on this form. Yes No

I give consent for Accessible Learning to contact my health care provider to discuss information specifically provided in this document. Yes No

I authorize the health care provider completing this form to share information with Accessible Learning at Wilfrid Laurier University about my disability and my disability-related functional limitations for the purposes of informing academic accommodations and support planning. Yes No

Confidentiality and Student Declaration

The information collected in this form is kept strictly confidential. Accessible Learning will not share any information collected in this form with anyone outside of Accessible Learning, including with others within the University, without your explicit consent.

By signing this form, I certify that the information provided is true, that the health care provider signing this form is the same person completing Section B of the form and is not a familial relative. Misrepresentation of information provided in this form may result in the denial or removal of academic accommodations or other supports provided by Accessible Learning.

Student Signature: Date:

**Accessible Learning
Brain Injury Disability Verification Form**

Section B: To be completed by Health Care Provider

About this Form

This form should be completed by one of the following appropriately licensed and trained health care providers, qualified to **diagnose an acquired brain injury** and provide an assessment of the associated functional limitations: **Family Physician, Neurologist, Neuropsychologist, Nurse Practitioner, or Sports Medicine Physician.**

Careful consideration should be given to the verification of disability and degree of functional limitation.

Please indicate what information you are basing the responses you provided on this form:

An assessment I completed with the student

A previous assessment completed by: 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 below:

- Permanent, continuous disability condition:** Student experiences ongoing functional limitations that will impact the student over the course of their academic career and are unlikely to change.
- Permanent, episodic disability condition:** Student experiences periods of good health, interrupted by periods of illness or disability over the course of their academic career.
- Persistent or prolonged disability condition:** These functional limitations are expected to last at least 12 months and is not a permanent disability. Student to be reassessed by:
- Temporary disability condition:** These functional limitations are temporary, or the severity may change, and should be reassessed in the future. Student to be reassessed by:
- Provisional disability condition:** I am still monitoring or assessing the student. Assessment is likely to be completed by:
- No disability:** The symptoms do not constitute a medical condition, or the medical condition is non-disabling in the academic environment.

Verification of Diagnosis

Before completing this section, please confirm on Page 1 of this form that the student has consented to the disclosure of their medical diagnosis. If the student consented, please specify their medical diagnosis using a clear diagnostic statement and any co-existing diagnoses. Avoid phrases 'suggests', 'is indicative of', etc.

Primary Diagnosis: Date:

Please indicate level of severity: Mild Moderate Severe

Secondary Diagnosis: Date:

Please indicate level of severity: Mild Moderate Severe

Additional Information:

Accessible Learning

Brain Injury Disability Verification

Clinical Assessment Information

Date of onset: Date of initial Assessment:

Date of most recent assessment: Date of next assessment:

Clinical Assessment Methods Used:

Clinical/Physical Examination Date:

Diagnostic Assessment Scales Date:

Disability Assessment Scales Date:

Clinical Interview/Behavioural Observation Date:

Other: Date:

Current Management

1. Does the student require medication support for their condition? Yes No

2. If the student is taking medication, are they currently symptom-free? Yes No

a. If the student is taking medication, please describe any side effects that impact the student's functioning:

3. Does the student require therapeutic treatments? Yes No

a. If yes, please specify types of therapeutic treatments:

4. Does the student require ergonomic equipment or assistive devices? Yes No

a. If yes, please specify types of equipment or devices used:

Disability Information

1. Has the student been hospitalized for this condition? Yes No

a. If yes, date of most recent hospitalization:

2. Has the student had previous brain injuries? Yes No

a. If yes, please indicate how many previous injuries:

3. Is the student's functioning restricted at certain times of the day? Yes No

a. If yes, please describe:

4. Is the student's sleep impacted by their condition? Yes No

a. If yes, please describe:

5. Is the student's speech impacted by their condition? Yes No

If yes, please describe:

Accessible Learning

Brain Injury Disability Verification

Functional Limitations and Impacts

Rate the severity of each symptom based on its impact on the student's academic functioning at university, using the scale below:

- **No Limitation:** The student does not require academic accommodation.
- **Mild:** The student should be able to cope with minimal support.
- **Moderate:** The student requires academic accommodations, as symptoms are more prominent.
- **Severe:** The student has a high degree of impairment and requires significant academic accommodations, as symptoms impact and interfere with academic functioning.
- **Unknown:** Unknown or unable to assess.

	No Limitation	Mild	Moderate	Severe	Unknown
Pain, headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness / balance problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision / perceptual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to screens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading print (paper)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration greater than 30 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration less than 30 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reasoning and thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizing and planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty making decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty self-regulating in daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty interacting with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty managing everyday stressors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty managing internal distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty managing external distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Accessible Learning

Brain Injury Disability Verification

Academic Functional Limitations

Using the same scale as on the previous page, 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.

	No Limitation	Mild	Moderate	Severe	Unknown
Regular and timely attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating in class/discussions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating in group projects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delivering presentations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completing exams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing multiple academic tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing competing deadlines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information processing – verbal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information processing – reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Express ideas in written form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reduced Course Load Information

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

1. Does the nature and severity of the student's disability **require** a reduced course load? Yes No
 - a. If yes, please estimate the maximum amount of time, in hours per week, that the student should be able to spend in these activities:
2. Will a reduced course load be required for the whole duration of the academic program? Yes No
 - a. If no, please explain:

Accessible Learning

Brain Injury Disability Verification

Additional Information

Please provide any other information about the student’s disability or functional limitations, including additional symptoms or academic limitations:

Health Care Provider Information

By signing below, I certify that this form was completed by me, and that the information provided on this form is accurate. I am providing the above information for use by the University in assessing what academic accommodations, if any, should be offered to the student. I understand I may be contacted by the University to verify this information but will not be requested to provide further information without the consent of the student.

Name (please print):

Telephone:

Specialty:

- Family Physician Neurologist
- Nurse Practitioner Sports Medicine Physician
- Other:

Official Stamp:

Registration Number:

Signature:

Date:

If you do not have an official stamp, please sign, date, and attach a page of your office letterhead.