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Accessible Learning

MENTAL HEALTH/PSYCHIATRIC: Disability Verification

This form should be completed by one of the following appropriately licensed and trained Health Care Professional (HCP):
Family Physician, Nurse Practitioner, Psychiatrist or Registered Psychologist.

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

DISCLOSURE OF DIAGNOSIS:

Note: You are **NOT** required to disclose your *diagnosis* in order to receive accommodations and supports. However, Accessible Learning does require confirmation of the presence of a disability and information about how it impacts you at university. Accessible Learning will use this information to recommend appropriate accommodations and supports for you at Laurier.

Do you consent to your diagnosis being identified on this form and communicated to Laurier's Accessible Learning? ☐ YES ☐ NO

CONFIDENTIALITY:

Information provided to Accessible Learning, including any diagnosis(es), 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 of academic accommodations.

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.

DIAGNOSTIC INFORMATION: (student must consent for completion)

If student consents on page one, please provide a clear diagnostic statement. (Include DSM-5 Code and diagnosis; avoid phrases such as 'suggests', 'is indicative of', etc.) **NOTE:** Indicate any co-existing diagnoses or concurrent conditions, indicating the DSM-5 code where applicable.

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.

DISABILITY INFORMATION:			
Please indicate level of severity:	☐ Mild	☐ Moderate	☐ Severe
Date of Onset: ______/ ______ / ______ (DD/MM/YR) Date of Most Recent Assessment: ______/ ______ / ______ (DD/MM/YR) Date of Next Assessment: ______/ ______ / ______ (DD/MM/YR)			
Has the student been hospitalized for treatment of this diagnosis?		☐ YES	☐ NO
If yes, please indicate date of most recent hospitalization: ______/ ______ / ______ (DD/MM/YR)			
Is the student's functioning restricted at certain times of the day? If so, please specify:	☐ Morning	☐ Afternoon	☐ Evening
Is the student's sleeping impacted by this diagnosis?	☐ YES	☐ NO	
If yes, please explain: ____			

CLINICAL ASSESSMENT METHODS USED: (Check all that Apply)	
☐ Psycho-diagnostic/Clinical Assessment	Date: ______________________
☐ Global Assessment of Functioning (GAF) or WHO-DAS	Score: ______________ Date: ____________
☐ Psychiatric Evaluation Date(s): ______________________________	
☐ Neuropsychological or psycho-educational assessment *Please provide a copy, including a list of tests completed and scores.*	Date(s): ______________________
☐ Behavioral Observations	
☐ Other:	

FUNCTIONAL LIMITATIONS/IMPACTS:

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

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 accommodation, as symptoms are more prominent.
Severe: The student has a high degree of impairment with significant academic accommodation required, as symptoms impact and interfere with academic functioning.
Unknown: Unknown or unable to assess at this time.

PHYSICAL:

Symptoms/Limitations	***No Limitation***	***Mild***	***Moderate***	***Severe***	***Unknown***
Pain					
Fatigue					
Headache					
Nausea					
Sensitivity to Light					
Sensitivity to Noise					

Comments:

THINKING:

Symptoms/Limitations	***No Limitation***	***Mild***	***Moderate***	***Severe***	***Unknown***
Concentration (long period more than 30 mins)					
Concentration (short period less than 10 mins)					
Processing Verbal Information					
Processing Written Information					
Reasoning and Thinking					
Organizing/Planning					

Comments:

SOCIO-EMOTIONAL:

Symptoms/Limitations	***No Limitation***	***Mild***	***Moderate***	***Severe***	***Unknown***
Irritability					
Difficulty Self-Regulating in Daily Activities					
Difficulty Interacting with Others					
Difficulty Managing Social Situations					
Nervousness					
Low Motivation					
Difficulty Making Decisions					
Difficulty Managing Stressors Related to Everyday Activities					
Difficulty Managing Internal Distractions					

Difficulty Managing External Distractions					
Coping with Multiple Demands					
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 Presentations					
Taking Notes					
Completing Exams					
Time Management					
Organization					
Planning					
Managing Multiple Academic Tasks					
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: ______________________hours per week

Will the reduced course load be required for the whole duration of the academic program to mitigate symptoms of the condition (for permanent, episodic, and persistent/prolonged conditions only)? ☐ YES ☐ NO

If no, please explain: ____

CURRENT MANAGEMENT: (Check all that Apply)	
☐ Psychotherapy/Counselling	☐ Massage Therapy
☐ Mental health support (Group/Individual)	☐ Occupational Therapy
☐ Complementary therapies (e.g., yoga, meditation)	☐ Other:

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

If yes, please specify any side effects that impact the student's academic 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**	☐ **Nurse Practitioner**
	☐ **Psychiatrist**	☐ **Registered Psychologist**
Health Care Professional Signature:	**Registration/License No.:**	
Date completed:	**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.