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Mental Health 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: _____

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 a mental health or psychiatric disability** and provide an assessment of the associated functional limitations: **Family Physician, Nurse Practitioner, Psychologist, Registered Psychologist, or specialist 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: _____

Clinical Assessment Information

Date of onset: | Date of initial Assessment:

Date of most recent assessment: | Date of next assessment:

Clinical Assessment Methods Used:

☐ Psycho-diagnostic/Clinical Assessment Date:

☐ Global Assessment of Functioning or WHO-DAS Date:

☐ Psychiatric Evaluation Date:

☐ Neuropsychological or psychoeducational assessment Date:

☐ Behavioural Observations 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 assistive aids, devices or supports? ☐ Yes ☐ No
   a. If yes, please specify types of devices used:

Disability Information

1. Has the student been hospitalized for this condition? ☐ Yes ☐ No
   a. If yes, date of most recent hospitalization:
2. Is the student's functioning restricted at certain times of the day? ☐ Yes ☐ No
   a. If yes, please describe:
3. Is the student's sleep impacted by their condition? ☐ Yes ☐ No
   a. If yes, please describe:
4. Is the student's speech impacted by their condition? ☐ Yes ☐ No
   a. If yes, please describe:

Functional Limitations and Impacts

Please indicate severity of each disability symptom based on their impact on the student's functioning in a university academic environment, using 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 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.

Physical Limitations	**No Limitation**	**Mild**	**Moderate**	**Severe**	**Unknown**
Pain, headache	○	○	○	○	○
Fatigue	○	○	○	○	○
Nausea	○	○	○	○	○
Sensitivity to light	○	○	○	○	○
Sensitivity to screens	○	○	○	○	○
Sensitivity to noise	○	○	○	○	○
Cognitive Limitations	**No Limitation**	**Mild**	**Moderate**	**Severe**	**Unknown**
Concentration greater than 30 minutes	○	○	○	○	○
Concentration less than 30 minutes	○	○	○	○	○
Reasoning and thinking	○	○	○	○	○
Organizing and planning	○	○	○	○	○
Difficulty making decisions	○	○	○	○	○
Socio-Emotional Limitations	**No Limitation**	**Mild**	**Moderate**	**Severe**	**Unknown**
Irritability	○	○	○	○	○
Nervousness	○	○	○	○	○
Low motivation	○	○	○	○	○
Difficulty self-regulating in daily activities	○	○	○	○	○
Difficulty interacting with others	○	○	○	○	○
Difficulty managing everyday stressors	○	○	○	○	○
Difficulty managing internal distractions	○	○	○	○	○
Difficulty managing external distractions	○	○	○	○	○

Academic Functional Limitations

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.

	No Limitation	Mild	Moderate	Severe	Unknown
Regular and timely attendance	○	○	○	○	○
Participating in class/discussions	○	○	○	○	○
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	○	○	○	○	○
Express ideas in written form	○	○	○	○	○

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: _____

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 ☐Registered Psychologist

☐Nurse Practitioner ☐Psychiatrist

☐Other:

Registration Number:

Official Stamp:

Signature: Date:

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