MEDICAL INFORMATION REQUEST FORM

Dear Health Care Professional,

You have been asked to complete this form by a student who wishes to register with Collège Boréal's *Services for Students with Disabilities*. We provide academic accommodations and educational support services for students with documented disabilities attending our College. Our goal is to provide the necessary accommodations to equalize the opportunity for students to meet their essential course or program requirements while maintaining academic integrity. We are mandated by the *Human Rights Commission's Guidelines for Accommodating Persons with Disabilities*, the *Ontario Human Rights Code, Accessibility for Ontarians with Disabilities Act, 2005* and Collège Boréal's policy regarding *Services for Students with Disabilities*.

The purpose of this form is to provide a system-wide approach for regulated health care professionals to document the functional limitations that a student with a disability is likely to experience at college. **We rely on your detailed knowledge of this student's disability, including a description of the current functional impairments that may impact his/her ability to meet essential course or program requirements and to determine appropriate academic accommodations**. This form is meant primarily for students who live with:

- **Permanent** mental health/medical disability with symptoms that are continuous or episodic and who are involved in college education.
- **Temporary** mental health/medical disability with symptoms that are continuous or episodic can also be accommodated through our office.
- Interim accommodations may also be provided for students who are in the process of being assessed for a medical/mental health disability.

As you know, the post-secondary environment involves taking examinations, doing research, completing assignments, and assuming responsibility for one's higher education pursuits. The information you have provided should clearly relate to accommodation planning for studies at the post-secondary level.

Under the Ontario *Human Rights Code*, it is not a requirement to provide a **specific diagnosis** to access accommodations and support services. Students are asked to indicate if they provide consent to release this information on **page one** of this document.

Thank you.

Telephone: 1.800.361.6673, ext. 2020
Email: besoinsparticuliers@collegeboreal.ca
Fax : 705.521.6004

MEDICAL INFORMATION REQUEST FORM

ATTENTION HEALTH PRACTITIONER: This form will be used as one of the criteria to determine eligibility for academic accommodations and support services at Collège Boréal. All information received will be kept strictly confidential and does not impact admission decisions.

Note: Students with Learning Disabilities
This form is not for information about a learning disability. Please submit a copy of the most recent psycho-educational assessment.

The student is responsible for costs associated (if applicable) with completing this form.

SECTION A: To be completed by student

Name: _____ D.O.B. (DD/MM/YYYY): _____

Phone: _____ Email: _____

Student consent to release of information pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____, authorize the health care professional to provide the following information to Collège Boréal's *Service aux étudiantes et aux étudiants ayant des besoins particuliers* (Services for Students with Disabilities). Under the Ontario Human Rights Code, it is not a requirement to provide a specific diagnosis to access academic accommodations and services from Collège Boréal.

Student consent to the disclosure of the diagnosis.
Please check one
❒ Yes, I give consent for a diagnosis to be provided.
❒ No, I do not give consent for a diagnosis to be provided.

_____ _____
Student Signature **Date**

SECTION B: To be completed by Regulated Health Care Professional

The following criteria must be met when determining a disability.
1. The student experiences functional limitation(s).
2. The functional limitation(s) impair(s) the student's academic functioning at the post-secondary level.

Select the appropriate option:

❒ 1. This student has a **permanent disability** with symptoms that are: ❒ continuous OR ❒ episodic.

❒ 2. This student has a **temporary disability** with symptoms that are: ❒ continuous OR ❒ episodic.

Interim academic accommodations to be provided until (date)*: _____
DD/MM/YYYY

❒ 3. This student is being monitored to determine a diagnosis.

Interim academic accommodations to be provided until (date)*: _____
DD/MM/YYYY

**Updated documentation required after this date*

Medication: Has the student been prescribed medication that may impact academic functioning? ❒Yes ❒ No
If yes, describe impact:

_____

_____

The student has the following **diagnosis (when consent given)**: When applicable, use DSM-5 criteria.

_____

IMPACT OF DISABILITY: Functional limitations evaluation (check appropriate boxes to indicate impact on academics)

Skills/Abilities	No Impact	Mild Impact	Moderate Impact	Severe Impact	Not assessed
COGNITION					
Attention/Concentration					
Long-term memory					
Short-term memory					
Executive functioning (i.e., planning, organising, problem solving)					
Information processing (i.e., auditory, verbal, written)					
Managing distractions					
PHYSICAL					
Mobility					
Gross motor					
Fine motor					
Ability to sit for a sustained period of time					
Ability to stand for a sustained period of time					
SENSORY					
Vision (with correction) : describe below					
Hearing (with correction) : describe below					
Speech : describe below					
SOCIAL / ÉMOTIONAL					
In-class and group work interactions					
Ability to perform class presentations					
OTHER (state)					

Please provide any additional comments or elaboration:

Do you consider the student capable of:

- Sustaining normal academic activity in their program of choice? ❒Yes ❒ No If no, please comment:

_____

- Participating in a work/field placement? ❒ Yes ❒ No If no, please comment :

_____

Recommended Accommodations:

- Reduced course load (reduced number of courses per semester) ❒ Yes ❒ No
- Special equipment (i.e., access to a computer, ergonomic furniture, amplification system) ❒ Yes ❒ No
- Adaptive Technology (i.e., specialised software) ❒ Yes ❒ No
- Specialised Services (i.e., peer assistant, tutor, note taker, accessible textbooks) ❒ Yes ❒ No
- Accommodations for tests and exams (i.e., extra time, distraction reduced room) ❒ Yes ❒ No
- Other: _____

Comments or additional information:

_____

_____

SECTION C: Certification of Regulated Health Care Professional

I, _____, am a legally qualified health care professional and this report
Please print full name
contains my findings and considered opinion at this time, within my scope of practice.

Signature: _____ Licence/Registration Number: _____

Date: _____ Email: _____

Phone: _____ Fax: _____

Medical Office Stamp:

Health Care Profession:

❒ Physician (family)
❒ Physician (other): _____
❒ Nurse/Nurse Practitioner
❒ Psychologist
❒ Other: _____

Thank you for taking the time to complete this form.

Please return the completed form to the student or e-mail to: besoinsparticuliers@collegeboreal.ca or Fax : 705-521-6004.