

## 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 *Accessibility Services*. 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 *Accessibility Standards for Customer Service and Integrated Accessibility Standards*.

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:** servicedaccessibilite@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 Accessibility Services 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
<b>COGNITION</b>					
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					
<b>PHYSICAL</b>					
Mobility					
Gross motor					
Fine motor					
Ability to sit for a sustained period of time					
Ability to stand for a sustained period of time					
<b>SENSORY</b>					
Vision (with correction) : describe below					
Hearing (with correction) : describe below					
Speech : describe below					
<b>SOCIAL / ÉMOTIONAL</b>					
In-class and group work interactions					
Ability to perform class presentations					
<b>OTHER (state)</b>					

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: [servicedaccessibilite@collegeboreal.ca](mailto:servicedaccessibilite@collegeboreal.ca)  
 or Fax : 705-521-6004.