Western
UNIVERSITY · CANADA

Documentation of Mental Health/Psychiatric Disability

Accessible Education

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This section to be completed and signed by the student PRIOR TO asking a health care professional to complete the Medical Documentation Form

Consistent with the Ontario Human Rights Commission's Policy on preventing discrimination based on mental health disabilities and addictions, students are not required to disclose their mental health disability diagnosis in order to register with Accessible Education (AE) and to receive academic accommodation. However, the Ontario Human Rights Commission recognizes that Disability Services Offices have expertise in dealing with accommodation issues in the academic environment, and as such, can play a vital role in assisting with the accommodation process. Students who want to disclose their diagnosis to SSD may do so.

☐ I Do ☐ I Do NOT (check one) consent to disclose the diagnosis of my mental health disability

Date : _____ Student Signature : _____

Dear Health Care Practitioner,

You have been asked by a student who wishes to register with Accessible Education (AE) at Western University to complete the enclosed documentation. A E is an educational support program only. **It is meant primarily for students who live with a chronic, persistent and permanent mental health disability and who are involved in university education. Significant temporary mental health disabilities can also be accommodated through our office.** Interim accommodations may be provided for students who are in the process of being assessed for a 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 purpose of the AE medical/psychiatric documentation is to enable Disability Counsellors to recommend appropriate academic accommodations for students with DSM diagnoses.

We are accountable under the *Ontario Human Rights Code* and *Western's Senate Policy on Accommodating Students with Disabilities.* These guidelines help us provide academic accommodations that level the playing field for students with disabilities without creating an unfair advantage or undermining academic integrity. **We rely on your detailed knowledge of this student's disability, including a list of the functional limitations and restrictions that may impact the student's education together with your recommendations for appropriate academic accommodations.**

Thank you for helping to reduce barriers for students with disabilities while upholding the academic standards of the university.

This form must be completed by a licensed medical practitioner or registered psychologist

Purpose of this form

Accessible Education (AE) requires documentation from a licensed psychiatrist, psychologist or family physician, who has in-depth knowledge of a student's condition, in order to arrange academic accommodation and/or related services. Information on this form also may be used to assess a student's eligibility for financial support. Documentation should be as complete as possible in order to facilitate AE's assessment of a student's request for services.

To be completed by student

Student Name: _____ **Date of Birth:** _____/_____/_____

(Year/Month/Day)

Student Number: _____

I authorize the professional named below to disclose to Accessible Education (AE) information on this form and additional or clarifying information that is necessary for provision of disability services at Western University. I also authorize AE to communicate with this professional in order to obtain information that is relevant to provision of AE's services.

Date : _____ _____ Student Signature : _____

Student's informed authorization for disclosure of information is obtained in accordance with the following sections of the *Freedom of Information and Protection of Privacy Act*. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the *use* of personal information and sections 42.(1)(b), s.42(1)(c), and s.42(1)(d) allowing for the *disclosure* of personal information.

To be completed by licensed health care professional

Name (please print):

_____

Registration Number:

_____

Address of professional:

_____

Telephone #: _____

_____

Fax #: _____

Profession:
☐ Psychologist ☐ Psychiatrist ☐ Family Physician ☐ Pediatrician ☐ Other_____

Signature:

_____

Date:

_____

Thank you for taking the time to complete this form. Feel free to include additional information on your official letterhead if needed.

NOTE: The following criterion must be met for the determination of a disability:

The student experiences functional limitations due to a mental health condition that impairs the student's academic functioning while pursuing post-secondary studies.

Please check one box on the left:

☐ I confirm that this student has a disability based on a diagnosed mental health condition according to the criterion outlined above.

Or

☐ I confirm that I am in the process of monitoring and assessing the student's mental health condition to determine a diagnosis and this assessment is likely to be completed by _____.
Date

Or

☐ The student's difficulties do not meet criteria for a diagnosis.

If the student has consented to disclosure of specific diagnosis to SSD (as indicated by the signature on page 1), please provide the DSM-5 code & diagnosis. If more than one condition is present that may affect academic progress, please specify all relevant conditions.

_____

_____

Date of the condition's onset: _____

Date of most recent assessment: _____

How long have you been treating this student? _____

Statement of Permanent Disability

The designation of permanent disability has legal implications and is used in determining a student's eligibility for government grants and loans**.** Please refer to the following definition of permanent disability when answering the question below.

Permanent disability is defined as a functional limitation due to a disorder that restricts a person's ability to perform daily activities necessary to participate in post-secondary studies and that is expected to remain with the person for the person's expected life.

In your professional opinion, does the student's condition meet criteria for a permanent disability as defined above?

Yes □ No □

Please check the appropriate description(s) as they apply to this student's condition.

(Check all that apply)

☐ Not a disabling condition in the current academic setting

☐ Temporary disability: anticipated duration from _____ to _____

☐ Permanent disability with ongoing chronic symptoms

☐ Permanent disability with episodic symptoms

☐ Updated documentation regarding disability status should be reassessed every _____ because of the changing nature of the illness

☐ This student is in stable condition and able to cope with typical academic stressors

☐ I will be monitoring this student on a regular basis while he or she is attending university

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Medication

If this student has been prescribed medication for this condition, when is the medication likely to have a negative effect on academic functioning? (Check all that apply)

□ Morning □ Afternoon □ Evening □ N/A

Functional Implications

Please check abilities and activities that are affected by the student's current symptoms, as well as medication effects (if any).

Abilities & Activities	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know
Concentration					
Information processing					
Executive Functioning					
Ability to meet deadlines					
Exam situations					
Attendance					
Ability to manage stress					
Other (please specify):					