Centre for Accessible Learning

Student Support Services

MEDICAL INFORMATION REQUEST FORM

This form can be used to determine eligibility for academic accommodations only. **OSAP Recipients** must use the OSAP Disability Verification form to confirm permanent disability status.

Note: Students with Learning Disabilities
Please do not use this form for accommodations. Submit the most recent psycho-educational assessment.

SECTION A: To be completed by student

Name: _____ Student Number: _____

Phone: _____ Email: _____

D.O.B.: (DD/MM/YY): _____ Campus: ☐ Ottawa ☐ Pembroke ☐ Perth ☐ Online

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 the Centre for Accessible Learning (CAL) at Algonquin College. Under the Ontario *Human Rights Code*, it is not a requirement to provide a **specific diagnosis** to access academic accommodations and services from the CAL.

Check one:

☐ I give consent for a diagnosis to be provided

☐ I do not give consent for a diagnosis to be provided

_____ _____

Student Signature Date

SECTION B: To be completed by Regulated Health Care Professional. Refer to page 4 for more details

The following criteria must be met when determining a disability.

- The student experiences functional limitation(s) that impairs the student's academic functioning at the post-secondary level

Select the appropriate option:

☐ 1. This student has a **permanent** disability, (i.e. functional impacts are expected to remain with the person for the expected duration of their postsecondary studies), based on a diagnosed health condition.

☐ 2. This student has a **temporary** disability, based on a diagnosed health condition. Interim academic accommodations to be provided until (date)*: _____

☐ 3. This student is being **monitored** to determine a diagnosis. Interim academic accommodations to be provided until (date)*: _____ (**Updated documentation required after this date)*

Is this a new diagnosis? ☐ Yes ☐ No

Has there been a recent unexpected significant change in health status? ☐ Yes ☐ No

If Yes to either question, what is the approximate date of onset / date range of impact? _____

SECTION C: Disability information & impact on academic functioning. To be completed by Health Care Professional

- The student has the following **diagnosis (*when consent given on page 1)**. When applicable, use DSM-5 criteria.

_____

- **Medications:** Has the student been prescribed medication that may impact academic functioning?
  ☐ Yes ☐ No If yes, describe impact:

_____

Health Care Professional: Check boxes below as appropriate					
Skills/Abilities	**No Impact**	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Not assessed**
COGNITION					
Attention / Concentration	☐	☐	☐	☐	☐
Long-term Memory	☐	☐	☐	☐	☐
Short-term Memory	☐	☐	☐	☐	☐
Executive Functioning	☐	☐	☐	☐	☐
Information Processing	☐	☐	☐	☐	☐
Managing distractions (filter out stimuli)	☐	☐	☐	☐	☐
PHYSICAL					
Mobility	☐	☐	☐	☐	☐
Gross motor	☐	☐	☐	☐	☐
Fine motor	☐	☐	☐	☐	☐
Ability to sit for a sustained period of time	☐	☐	☐	☐	☐
Ability to stand for a sustained period of time	☐	☐	☐	☐	☐
SOCIAL / EMOTIONAL					
In-class and group work interactions	☐	☐	☐	☐	☐
Ability to perform class presentations	☐	☐	☐	☐	☐
SENSORY / COMMUNICATION					
Vision:	☐	**Describe impact below**			☐
Hearing:	☐				☐
Speech:	☐				☐

Please provide any specific restrictions, additional comments or relevant information:
If any of the above impacts are severe, please elaborate:

SECTION D: Disability information & impact in experiential learning settings. To be completed by Health Care Professional

Many programs at Algonquin College offer experiential learning opportunities (e.g., co-op, work term, clinical placement). If there are any disability-related impacts in these settings, please describe specific restrictions and/or accommodation needs.

SECTION C: Regulated Health Care Professional information

How long has this student been your patient? _____ Years / Months (please circle) OR ☐ 1st Visit

While this student is enrolled at the college, will you be monitoring their health?

☐ Yes. Frequency: _____
☐ No. Will be followed by (if known):_____

Please print.

I, _____, am a legally qualified health care professional and this report 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:
_____
☐ Psychologist / Psychological Associate
☐ Other:
_____

Completed form to be returned to appropriate campus:

Centre for Accessible Learning Algonquin College 3rd Floor, Student Commons 1385 Woodroffe Avenue Ottawa, ON, K2G 1V8 Fax: 613.727.7862 Tel: 613.727.4723 x 7200 Email: **welcomecentre@algonquincollege.com**	Centre for Accessible Learning Algonquin College in the Ottawa Valley 1 College Way Pembroke, ON, K8A 0C8 Fax: 613.735.8805 Tel: 613.735.4700 x 2665 Email: **calpembroke@algonquincollege.com**	**Perth / Online:** Please submit to the Ottawa campus

Dear Health Care Professional,

You have been asked to complete this form by a student who wishes to register with the Centre for Accessible Learning (CAL) at Algonquin College. CAL provides academic accommodations and educational support services for students with documented disabilities attending Algonquin 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 and Algonquin College Policy AC01.

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 the functional impacts are expected to remain with the person for the expected duration of their postsecondary studies.
- **Temporary** medical/mental health 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 from CAL. Students are asked to indicate if they provide consent to release this information on **page one** of this document.

Thank you