DOCUMENTATION OF MENTAL HEALTH DISABILITY

STUDENT

☐ I understand that this form will be released to SASS – Academic Accommodations, University of Ottawa for the following purposes:

- to confirm the presence of an acquired a mental health disorder;
- to identify if the condition is permanent or temporary;
- to evaluate functional limitations in the learning environment;
- to help SASS – Academic Accommodations determine appropriate accommodations and supports.

** The information you provide in the form can be used to assess the need for learning supports, academic accommodations, or access to a range of benefits including government funding.*

STUDENT NAME _____ STUDENT NUMBER _____

STUDENT SIGNATURE _____ DATE _____

WHO CAN COMPLETE THE FORM?

The documentation form is **to be completed by a treating Family Physician, Nurse Practitioner, Psychiatrist or Psychologist**. The health professional has knowledge of the patient's history and is licensed to diagnose and treat the medical condition. **Students are not to fill out the medical form or functional limitations**.

IS A DIAGNOSIS REQUIRED?

No, but if a diagnosis is not provided, functional limitations must be fully described and additional information may be requested in order to determine appropriate accommodations and supports.

WHO SEES AND USES THIS INFORMATION?

Information provided will be used for the purposes described above and confidential in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA) and Personal Health Information Protection Act (PHIPA). If you have any further questions please contact us.

TO BE FILLED OUT BY TREATING FAMILY PHYSICIAN, NURSE PRACTITIONER, PSYCHIATRIST OR PSYCHOLOGIST

DSM-V DIAGNOSIS

IF THE STUDENT HAS CONSENTED TO DISCLOSE A SPECIFIC DIAGNOSIS, PLEASE STATE THE DSM-V DIAGNOSIS.

☐ IN MY PROFESSIONAL OPINION, I CONFIRM THE STUDENT HAS A FORMALLY DIAGNOSED MENTAL HEALTH DISABILITY.

OR

☐ I CONFIRM THAT I AM IN THE PROCESS OF ASSESSING THE STUDENT'S CONDITION TO DETERMINE A DIAGNOSIS.

DURATION OF DISABILITY

☐ **PERMANENT:** The disability is expected to remain for the duration of postsecondary studies.

☐ **TEMPORARY:** The disability is expected to remain from YEAR MONTH DAY to YEAR MONTH DAY

☐ **UNKNOWN DURATION** *(Note: accommodations will be established for one semester until additional documentation is provided).*

FLUCTUATING SYMPTOMS

☐ The student's disability has symptoms that can fluctuate.

TREATMENT PLAN Please update this document if the treatment plan changes.

1. **IF A DIAGNOSIS HAS BEEN CONFIRMED, PLEASE PROVIDE DATE OF FIRST DIAGNOSIS:**
2. **WILL YOU BE MONITORING THE STUDENT ON A REGULAR BASIS?**
   ◯ YES, EVERY ◯ NO, THIS STUDENT WILL BE FOLLOWED BY
3. **IF THE STUDENT HAS BEEN PRESCRIBED MEDICATION FOR THIS CONDITION, CAN YOU SPECIFY CURRENT (IF ANY) SIDE EFFECTS THAT MAY IMPAIR THE STUDENT'S ACADEMIC PERFORMANCE?**
4. **DOES THE STUDENT HAVE LIMITED FUNCTIONING AT CERTAIN TIMES OF THE DAY? PLEASE CHECK ALL THAT APPLY:**
   ☐ MORNING ☐ AFTERNOON ☐ NIGHT
5. **ARE THERE OTHER TREATMENTS OR THERAPIES THAT THE STUDENT RECEIVES?**

SASS - Accommodation Services
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FUNCTIONAL LIMITATIONS THAT IMPACT THE UNIVERSITY ENVIRONMENT

NO IMPACT	MILD IMPACT	MODERATE IMPACT	SEVERE IMPACT
Unlikely to have an effect on ability to fulfill academic obligations.	Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms.	Student requires moderate supports or accommodations to succeed.	Significantly impaired in ability to fulfill academic obligations e.g. unable to complete some assignments, unable to write some tests/ examinations.

ATTENTION AND CONCENTRATION	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
MANAGING INTERNAL DISTRACTIONS	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
MANAGING EXTERNAL DISTRACTIONS	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
MEMORY	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
INFORMATION PROCESSING	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
RATIONAL THINKING	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
TIME MANAGEMENT	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
ORGANIZATION	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
CLASS PARTICIPATION	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
ABILITY TO CONTROL EMOTIONS	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
STRESS MANAGEMENT	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
ENERGY LEVEL	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:
OTHER	☐ NO IMPACT ☐ MILD IMPACT	☐ MODERATE IMPACT ☐ SEVERE IMPACT	IF SEVERE, DESCRIBE THE IMPACT:

ACADEMIC WORKLOAD

UNDERGRADUATE: A minimum of 4 courses per semester is typically considered full-time.

GRADUATE: A minimum of 2 courses per semester is typically considered full-time.

1. BASED ON YOUR PROFESSIONAL OPINION, DO YOU THINK THE STUDENT IS ABLE TO MAINTAIN A COURSE LOAD OF:

5 OR MORE COURSES? ○ YES ○ NO | 4 COURSES (REDUCED FULL TIME)? ○ YES ○ NO | 2-3 COURSES? ○ YES ○ NO

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ADDITIONAL INFORMATION

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MAY ASSIST US IN SUPPORTING THE STUDENT.

VERIFICATION OF ASSESSING PROFESSIONAL

PLEASE SPECIFY TYPE OF PRACTITIONER:

☐ PSYCHOLOGIST ☐ PSYCHIATRIST ☐ NURSE PRACTITIONER ☐ FAMILY PHYSICIAN ☐ OTHER

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	CPSO / REGISTRATION #
ADDRESS	
PHONE NUMBER	FAX NUMBER

STAMP (IF AVAILABLE):

SIGNATURE

DATE

Note: The student is responsible for costs associated with completing this certificate.

The personal information on this form is collected under the authority of the University of Ottawa Act, S.O. 1965, C.137. At all times the personal information will be protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have any questions regarding this collection, please contact **the Access to Information and Privacy Office (AIPO)**.

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