YORK UNIVERSITÉ UNIVERSITY

Physical, Sensory and Medical Disability Services

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Physical, Sensory and Medical Disability Services
Counselling & Disability Services
Medical Documentation

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 Guidelines on Accessible Education, you are not required to disclose your physical, sensory and medical disability diagnosis in order to register with Physical, Sensory and Medical Disability Services (PSMDS) and to receive academic accommodation. 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. If you wish to, you may voluntarily disclose your diagnosis to PSMDS.

Providing your diagnosis may be required to establish eligibility for certain federally or provincially-funded bursaries and grants and privately funded external scholarships and financial awards. This Form can be used to establish eligibility for such financial assistance, provided you have consented to the disclosure of your physical, sensory and medical diagnosis.

If you choose to consent to the disclosure of your diagnosis, you must check the box below. Your consent will allow your Health Care Practitioner to complete the relevant section of the Form.

☐ I consent to disclose the diagnosis of my physical, sensory or medical disability

____
Signature of Student:

Please Print:

Student's Last Name: ____

Student's First Name: ____

Date of Birth(mm/dd/yyyy): ____

Student Number: ____

Address: ____

____

Phone (Home/Cell): ____

Email Address: ____

Dear Health Care Practitioner,

You have been asked by a student who wishes to register with Physical, Sensory and Medical Disability Services (PSMDS) at York University to complete the enclosed documentation. PSMDS is an educational support program only. It is meant primarily for students who live with a chronic, persistent and permanent physical, sensory or medical health disability and who are involved in university education. Significant temporary physical, sensory and medical 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 physical, sensory and medical 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 PSMDS medical/psychological documentation is to enable Disabilities Counsellors to recommend appropriate academic accommodations for students with disabilities.

We are accountable under the *Ontario Human Rights Code* and *York'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 their 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

Functional Limitations Assessment Form for Post-Secondary Students with a Physical, Sensory and/or Medical Disability

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

The student experiences functional limitations due to a 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 physical, sensory and/or medical health condition according to the criterion outlined above.

Or

☐ I confirm that I am in the process of monitoring and assessing the student's physical, sensory and/or medical health condition to determine a diagnosis and this assessment is likely to be completed by

__________________________.
Date

If the student has consented to disclosure of specific diagnosis to PSMDS (as indicated by their signature on page 1), please provide the diagnosis in the space below.

Nature of Disability:

____
____
____

Duration of Disability:

Complete 1 OR 2 OR 3

1. This student has a **permanent disability** (*physical, sensory and/or medical disability is expected to be lifelong)* with symptoms that are:

   ☐ continuous OR
   ☐ recurrent/episodic

2. This student has a **temporary disability** with symptoms that are:

   ☐ continuous OR
   ☐ recurrent/episodic
   Accommodations to be provided from ______________ to _________________*

3. ☐ This student is **being assessed** to determine a diagnosis.*

* Updated documentation will be required by PSMDS to continue providing academic accommodation.

*For conditions that are recurrent/episodic, please provide information on the:

Frequency and Duration:____

Contributing Factors: ____

Medication:

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

☐ Morning ☐ Afternoon ☐ Evening ☐ N/A

Possible side effects of medication that would impact on their participation at university:
____

____

<u>Functional Limitations</u>

Using the following scale, please rate the impact of the impairment caused by the disability as well as possible medication effects (if any) on the areas of functioning below.

1	2	3	4	0
Within normal limits No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area	Unable to assess or unknown at this time

A. Physical Skills/Abilities

Mobility ☐1 ☐2 ☐3 ☐4 ☐0

Gross Motor ☐1 ☐2 ☐3 ☐4 ☐0

Fine Motor/
Manual Dexterity ☐1 ☐2 ☐3 ☐4 ☐0

Stamina/Ability to
Engage in academic activities ☐1 ☐2 ☐3 ☐4 ☐0

Sit for sustained periods of time ☐1 ☐2 ☐3 ☐4 ☐0

Sleep disturbance ☐1 ☐2 ☐3 ☐4 ☐0

Other: ☐1 ☐2 ☐3 ☐4 ☐0

Please describe:

Comments: *Please elaborate on any of the areas above that need further explanation.*

Functional Limitations

Using the following scale, please rate the impact of the impairment caused by the disability as well as possible medication effects (if any) on the areas of functioning below.

1	2	3	4	0
Within normal limits No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area	Unable to assess or unknown at this time

B. Cognitive Skills

Attention/Concentration ☐1 ☐2 ☐3 ☐4 ☐0

Short-Term Memory	☐1	☐2	☐3	☐4	☐0
Long-Term Memory	☐1	☐2	☐3	☐4	☐0
Information Processing	☐1	☐2	☐3	☐4	☐0
Ability to Manage Distractions	☐1	☐2	☐3	☐4	☐0
Executive Functioning Planning, Organizing, Problem solving, Sequencing, Time-management	☐1	☐2	☐3	☐4	☐0
Ability to Meet Assignment Deadlines	☐1	☐2	☐3	☐4	☐0
Other	☐1	☐2	☐3	☐4	☐0

Please describe:

Comments: *Please elaborate on any of the areas above that need further explanation:*

Functional Limitations

Using the following scale, please rate the impact of the impairment caused by the disability as well as possible medication effects (if any) on the areas of functioning below.

1	2	3	4	0
Within normal limits No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area	Unable to assess or unknown at this time

C. Vision (Visual acuity loss (best corrected), left eye, right eye, bilateral, visual field limitations)

☐1 ☐2 ☐3 ☐4 ☐0

☐Low Vision: ☐Left eye ☐Right eye ☐Bilateral
☐Blindness: ☐Left eye ☐Right eye ☐Bilateral

The Symptoms are: ☐Stable ☐Progressive

Adaptive technology and/or Aids used:

A description of the functional limitation(s) and academic impact caused by the disability,
(E.g. Reading, viewing blackboards and PowerPoints, mobility, etc.)

Comments: *Please elaborate on any of the areas above that need further explanation:*

D. Hearing Loss

Current Audiogram is available ☐Yes ☐No

Results of an audiogram showing the degree of hearing loss

☐Mild ☐Moderate ☐Severe/Profound ☐Deaf

The symptoms are: ☐Stable ☐Progressive

Adaptive technology and/or Aids used:

A description of the functional limitation(s) and academic impact caused by the disability.

Comments: *Please elaborate on any of the areas above that need further explanation:*

E. Speech

Using the following scale, please rate the impact of the impairment caused by the disability as well as possible medication effects (if any) on the areas of functioning below.

1	2	3	4	0
Within normal limits No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area	Unable to assess or unknown at this time

Overall Impact ☐1 ☐2 ☐3 ☐4 ☐0

Comments: *Please elaborate on any of the areas above that need further explanation:*

F. Safety

Does this student have a condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus our during fieldwork, (e.g. seizure disorder, severe allergic reaction)

☐YES ☐NO

If "yes", please describe condition(s)

____

____

____

Please list any additional functional limitations that may impair the student's academic functioning in the post-secondary setting:

____

____

____

Comments: *Please elaborate on any of the areas above that need further explanation.*

Using the following scale, please rate the impact of the impairment caused by the disability as well as possible medication effects (if any) on the areas of functioning below.

1	2	3	4	0
Within normal limits No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area	Unable to assess or unknown at this time

OVERALL ACADEMIC IMPACT

Note taking	☐1	☐2	☐3	☐4	☐0
Group Participation	☐1	☐2	☐3	☐4	☐0
Oral Presentations	☐1	☐2	☐3	☐4	☐0
Meeting Deadlines	☐1	☐2	☐3	☐4	☐0
Exams & Tests	☐1	☐2	☐3	☐4	☐0
Attendance	☐1	☐2	☐3	☐4	☐0

No class attendance for ________ Days / Partial class attendance starting ________ to _________ .

RECOMMENDED ACADEMIC ACCOMMODATIONS:

Based on the functional limitations that you identified above, do you have recommendations for specific academic accommodations (e.g. reduced course load, extended time to complete tests/ exams, flexibility in assignment due dates, assistive technology, note-taking supports, etc.)?

____

____

____

Student's strengths:

____

____

____

____

Date Completed (mm/dd/yyyy): ______________________________

Practitioner’s Name (please print): ______________________________

Practitioner’s Signature: ______________________________

Medical Practitioner’s License Number: ______________________________

Registered Psychologist’s Registration Number: ______________________________

Name/Address/Phone Number →

Please use office stamp as well as signature

Return completed form to N108 Ross or fax this form to: 416-650-8068, Physical, Sensory and Medical Disability Services, York University, Attention: Karen Swartz

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Student Consent

Completion of this section is voluntary; however, if you elect not to provide your consent at this time and in the event that further information is required there may be delays in the provision of your accommodation.

I give consent for PSMDS to contact my medical practitioner or registered psychologist to discuss the information provided in this document if necessary to clarify the information provided regarding functional restrictions and limitations or if there are questions about complex academic accommodation.

Student’s Signature: ______________________________

Date: (mm/dd/yyyy): ______________________________

****Note to student:** If you have other relevant documentation, you may include copies of it with this registration package. These additional documents are not intended to replace the PSMDS registration package. Please note - additional documentation may be requested