

Academic Accommodations Services

DOCUMENTATION OF ADHD

Student:

I understand that this form will be released to Academic Accommodations Services, University of Ottawa.

- to confirm the presence of ADHD;
- to identify if the condition is permanent or temporary;
- to evaluate functional limitations in the learning environment;
- to help Academic Accommodations Services 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

YEAR	MONTH	DAY	
DATE			

Who can complete the form?

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

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.

Academic Accommodations Services

100 Marie-Curie Private, Room 408 Ottawa ON K1N 9N3
adapt@uOttawa.ca | Telephone: 613.562.5976 | Fax 613.562.5159



TO BE ONLY FILLED OUT BY A REGISTERED PSYCHOLOGIST, NEUROPSYCHOLOGIST, PSYCHIATRIST, OR TREATING FAMILY PHYSICIAN)

Diagnostic Statement

I confirm that I am in the process of assessing the student's condition to determine a diagnosis.

-OU-

I confirm the diagnosis of **Attention-Deficit/Hyperactivity Disorder (ADHD)** with subtype:

- predominantly inattentive predominantly hyperactive/impulsive
 combined

I confirm that the degree of impairment is: mild moderate severe

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. How long have you been treating the student? _____
3. Will you be monitoring the student on a regular basis?
Yes, every _____ .
 No, this student will be followed by _____ .
4. 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?

5. Does the student have limited functioning at certain times of the day? Please check all that apply:
 Morning Afternoon Evening
Please specify: _____
6. Does the student receive other treatments or therapies?

7. Please note any multiple diagnoses or concurrent conditions:

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Functional Limitations that Impact the University Environment

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

Attention and concentration	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Managing internal distractions	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Managing external distractions	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Memory	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Information processing	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Rational thinking	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Time management	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Organization	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Class participation	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Attendance	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Ability to control emotions	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Stress management	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Energy Level	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				
Other:	<input type="radio"/> no impact	<input type="radio"/> mild impact	<input type="radio"/> moderate impact	<input type="radio"/> severe impact
Describe impact:				

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Academic Considerations

Undergraduate: A minimum of 5 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

Additional Information

Please provide any additional information that may assist us in supporting the student.

VERIFICATION OF ASSESSING PROFESSIONAL

Please specify type of practitioner:

- Registered Psychologist
- Neuropsychologist
- Psychiatrist
- 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: _____

College / Registration #: _____

Address: _____

Telephone #: _____

Fax #: _____

Signature : _____

Stamp (if available):

YEAR	MONTH	DAY
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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