DOCUMENTATION OF MENTAL HEALTH DISABILITY

STUDENT

☐ I understand that this form will be released to Academic Accommodations6HUYLFHV, 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 Academic Accommodations6HUYLFHV 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**

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?**

Accommodation Services
, 5RRP , Ottawa, ON K1N
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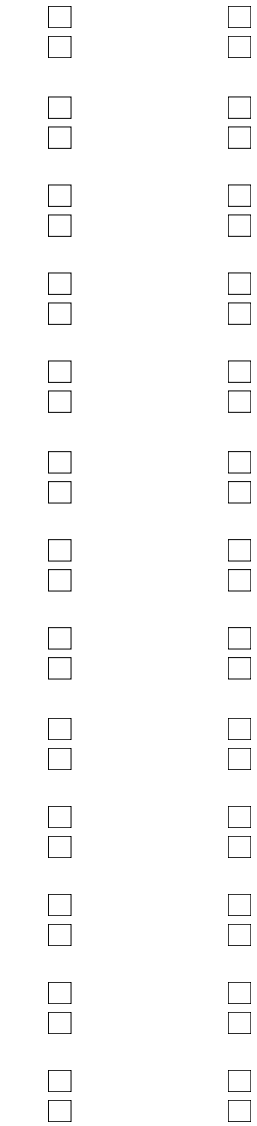
uOttawa



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