DOCUMENTATION OF ATTENTION DEFICIT/HYPERACTIVITY DISORDER

PART 1. STUDENT INFORMATION

Student Name: ____________________________________________________________

Date of Birth: _______/_____/_______  Student #: ________________________________
  Month  Day  Year

PART 2. DOCUMENTATION OF DISABILITY

A. To be completed by the registered Psychiatrist, Psychologist, or a treating Family Physician. At the discretion of SAS, documentation from a General Practitioner is accepted for the purpose of establishing temporary/interim disability services and accommodations while a diagnosis is being explored or evaluated. All sections of the form must be completed carefully and objectively to ensure accurate assessment of the student’s disability-related needs.

B. Careful consideration should be given to the statement of disability and degree of impairment.

Disability is defined as a functional limitation or impairment that is related to a student’s ability to perform the daily activities necessary to participate in post-secondary studies. The degree of disability can range from mild to moderate, severe, or profound.

Does this student have a disability according to the above definition?

☐ Yes  ☐ No

Statement of Disability (Prognosis):

Please select ONE of the following statements that apply to the student in the current academic setting

☐ Permanent – Chronic (ongoing symptoms for the duration of natural life)
☐ Permanent – Acute (recurring episodes with relatively symptom free period of remission)

The following criteria must be met for determination of permanent disability:

- Functional limitation due to a medical condition
- Functional limitation that restricts ability to perform daily activities necessary to participate in post-secondary studies
- Functional limitation that is expected to be life long

For OSAP purposes, a permanent disability is defined as a functional limitation caused by a physical or mental impairment that restricts a student’s ability to perform the daily activities necessary to participate in studies at the postsecondary level or labour force. It is expected that the condition will remain with them and need to be managed over the course of their life.

Diagnostic Statement:

State your DSM-5 diagnosis for this student, including the type of AD/HD. Provide a clear diagnostic statement and note any multiple diagnoses or concurrent conditions:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
Degree of Impairment or Limitation is:  [ ] Mild  [ ] Moderate  [ ] Severe/Profound

DETAILED EVALUATION

1. Date the diagnosis was first established: _____________________________

2. Date the student was most recently seen by you: _____________________________

3. Please check which of the major life activities below are affected by the student's current symptoms and indicate the level of limitation.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>No Impact</th>
<th>Mild Impact</th>
<th>Moderate Impact</th>
<th>Severe Impact</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention and concentration</td>
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<tr>
<td>Memory</td>
<td></td>
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<tr>
<td>Information processing (written, verbal)</td>
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<tr>
<td>Stress management</td>
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<td>Managing distractions</td>
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<tr>
<td>Organization and time management</td>
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<td>Timely completion of tasks</td>
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<tr>
<td>Other (please specify):</td>
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</tbody>
</table>

4. Is this student currently taking medication(s) for their symptoms?  [ ] Yes  [ ] No

   If yes, please list the patient’s current medications and how they may impact their activities of daily living, particularly academic performance (e.g. time of day, alertness, concentration, fatigue etc.)

   ___________________________________________________________________________________________________

   ___________________________________________________________________________________________________

5. If the student does take medication(s), do limitations or symptoms persist even with the medication(s)?

   [ ] Yes  [ ] No

   If yes, please describe the residual limitations or symptoms:

   ___________________________________________________________________________________________________

   ___________________________________________________________________________________________________

6. Is the student involved in any other (i.e. non-pharmacological) treatment for their symptoms?

   ___________________________________________________________________________________________________

   ___________________________________________________________________________________________________
7. If the student is not receiving any treatment, please state the reasons or provide an explanation:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

8. While this patient is enrolled at the University, will you be monitoring him/her on a regular basis?

   Yes, every: __________________________________________________

   No, this student will be followed by: ____________________________________________

9. Please provide additional information that may assist us in determining appropriate disability services.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

CERTIFICATE OF ATTENDING PROFESSIONAL

*Please affix a business card if your office does not have a stamp*

Name: ___________________________________________________
Signature: _________________________________________________
Designation: _____________________________________________
Registration #: __________________________________________
Date: _____________________________________________________
Telephone: _______________________________________________
Fax: ______________________________________________________

PART 3. STUDENT’S WRITTEN AND INFORMED CONSENT AND RELEASE TO SHARE INFORMATION

I _________________________________ (student name) authorize and give consent for the information
regarding my disability provided on this form be released to authorized persons within the UOIT Student Accessibility
Services office for the purpose of establishing or reviewing academic accommodations.

I give consent for authorized persons within Student Accessibility Services to contact the health professional listed
on this form to discuss the information regarding my disability and accommodation needs outlined on this form.

Student Signature: __________________________________________ Date: __________________________