### PART 1. STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Student Name:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>__________/<strong><strong><strong><strong>/</strong></strong></strong></strong></td>
</tr>
<tr>
<td></td>
<td>Month       Day       Year</td>
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</tbody>
</table>

### 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, especially if 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. 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 this student was most recently seen by you: ____________________________________

3. Is there a co-existing diagnosis?  
   - [ ] Yes  
   - [ ] No

   If yes, what type? __________________________________________________________________

   Is additional documentation available to support this diagnosis?  
   - [ ] Yes  
   - [ ] No

   If yes, please describe:

   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

4. Is the student currently taking medication?  
   - [ ] Yes  
   - [ ] No

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

   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

5. Is this student a regular patient of yours?  
   - [ ] Yes  
   - [ ] No

   a. If Yes, please indicate any services that you are currently providing

   Medication therapy  
   - [ ] Yes  
   - [ ] No

   Psychotherapy  
   - [ ] Yes  
   - [ ] No

   Other (please describe: ________________________________)

6. Do you consider this student to be in stable condition and capable of sustaining normal academic stress with appropriate supports?  
   - [ ] Yes  
   - [ ] No

   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
7. While this student is enrolled at the University, will you be monitoring him/her on a regular basis?
   
   ______ Yes, every: _____________________________
   
   ______ No, this student will be followed by: _____________________________

8. Using the chart below, please indicate the expected impact on academic life/work at university:

<table>
<thead>
<tr>
<th>Academic/ 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>Processing speed</td>
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<tr>
<td>Communication/ language skills</td>
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<tr>
<td>Organization and time management</td>
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<tr>
<td>Appropriate classroom participation</td>
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<tr>
<td>Timely completion of tasks and attendance</td>
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<tr>
<td>Group projects</td>
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<tr>
<td>Sensitivity to environmental conditions</td>
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<td>Oral participation</td>
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<td>Adaptation to scheduling changes</td>
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<td>Personal hygiene</td>
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<tr>
<td>Social interaction</td>
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<tr>
<td>Activities of daily living (If living away from home)</td>
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<tr>
<td>Other (please specify):</td>
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</table>

9. What specific academic accommodations do you recommend?
   
   __________________________________________________________________________
   
   __________________________________________________________________________
   
   __________________________________________________________________________
   
   __________________________________________________________________________

10. What disability-based supports do you recommend?

   a. Personal Counseling ______
   b. Social Skills Training ______
   c. Learning Strategy/ Time Management Coach ______
   d. Peer Mentor ______
   e. Other (please describe): ________________________________________________
11. 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: _____________________________