MENTAL HEALTH DISABILITY VERIFICATION FORM

AccessAbility Services - University of Waterloo
1401 Needles Hall, 200 University Avenue West, Waterloo, ON N2L 3G1
P. 519.888. 4567 ext. 35082. F. 519.746.2401
Web: uwaterloo.ca/accessability-services I E-mail: access@uwaterloo.ca

TO BE COMPLETED BY STUDENT

SECTION 1: STUDENT INFORMATION

Student information (please print)	
Last name:	
First name:	
Date of birth (DD/MM/YYYY):	
Waterloo ID number:	
Phone number (home/cell)	
Waterloo e-mail address:	@uwaterloo.ca

SECTION 2: DISCLOSURE OF DIAGNOSIS

Note: You are **NOT** required to disclose your *medical diagnosis* in order to receive accommodations and supports, but a diagnosis may be required to establish eligibility for specific supports (e.g. funding). While the provision of a specific diagnosis is voluntary, AccessAbility Services does require verification of the nature of your disability and, more importantly, the functional limitations within your academic environment. AccessAbility Services will use this information to establish appropriate accommodations and supports for you at the University of Waterloo.

- ☐ I consent to disclose my diagnosis and will direct my regulated health care practitioner to fulfill this request.
- ☐ I do not consent to disclose my mental health diagnosis. However, I am aware that my regulated health care practitioner will identify my functional limitations.

SECTION 3: CONFIDENTIALITY & AUTHORIZATION FOR RELEASE OF INFORMATION

Information provided in this form, including any medical diagnosis(es), is kept ***strictly confidential***. It is not shared with anyone outside of AccessAbility Services, including with other university departments, without the expressed and written consent and/or direction of the student.

By signing below, I give consent for the University of Waterloo AccessAbility Services to contact the service provider who completed this form to discuss information provided in this document, if necessary, to clarify information regarding functional limitations or if there are questions related to my application.

Student's signature:	Date completed (DD/MM/YYYY):

Student's informed authorization for disclosure of information is obtained in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), -s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

TO BE COMPLETED BY HEALTH CARE PRACTITIONER

This form should be completed by one of the following appropriately licensed and trained professionals, **qualified to diagnose a mental health condition** and provide an assessment of the associated functional limitations: Psychologist, Psychiatrist, Family Physician.

The University of Waterloo requires your detailed assessment of this student's disability, especially how its **limitations or restrictions may impact their ability to access and participate in post-secondary studies.** Careful consideration should be given to the **verification of disability** and **degree of functional limitations** in the sections below. The designation of permanent disability has legal implications and can impact the student's eligibility for funding.

SECTION 4: VERIFICATION OF DISABILITY

If the student consented above to disclose their medical diagnosis, please provide a clear diagnosis and include the DSM-5 Code. **Note:** Indicate any co-existing diagnosis(es) or concurrent conditions, indicating the DSM-5 code where applicable.

Diagnosis(es): _____

_____

_____

_____

_____

SECTION 5: DURATION OF ASSOCIATED FUNCTIONAL LIMITATIONS

- ☐ **Permanent, continuous:** Ongoing functional limitations that will impact the student over the course of their academic career and are unlikely to change
- ☐ **Permanent, episodic:** Periods of good health interrupted by periods of illness or disability over the course of their academic career
- ☐ **Temporary:** These functional limitations are temporary, or the severity may change, and should be reassessed in future. Student to be reassessed by: _____/_____/_____ (DD/MM/YYYY)
- ☐ **Provisional:** I am still monitoring/assessing the student. Assessment likely to be completed by: _____/_____/_____ (DD/MM/YYYY)
- ☐ **No disability:** The symptoms do not constitute a medical condition, or the medical condition is non-disabling in the academic environment

SECTION 6: ASSESSMENT INFORMATION

How long have you been **regularly** evaluating the student for the presenting concerns?

- ☐ Seen for the first time today
- ☐ 1 week or less
- ☐ 6 months or less
- ☐ 1 year or less
- ☐ More than 1 year

How many times have you assessed/treated the student for the presenting concerns? _____

Will you be monitoring/treating the student while they are at University? ☐ Yes ☐ No

SECTION 7: CLINICAL ASSESSMENT METHODS USED (check all that apply)

- ☐ Clinical assessment — Date: _____/_____/_____ (DD/MM/YYYY)
- ☐ Global Assessment of Functioning (GAF) or WHO-DAS — Score: _____
- ☐ Psychiatric or Psychological evaluation — Date: _____/_____/_____ (DD/MM/YYYY)
  (Please provide a copy of report, if applicable)
- ☐ Neuropsychological or psycho-educational assessment — Date: _____/_____/_____ (DD/MM/YYYY)
  (Please provide a copy of report, if applicable)
- ☐ Behavioral observations
- ☐ Student self-report
- ☐ Other: _____ Date: _____/_____/_____ (DD/MM/YYYY)

SECTION 8: DISABILITY INFORMATION

Please indicate level of severity of condition: ☐ Mild ☐ Moderate ☐ Severe

Date of onset of disability: Date: _____/_____/_____ (DD/MM/YYYY)

Date of most recent assessment: Date: _____/_____/_____ (DD/MM/YYYY)

Date of next assessment: Date: _____/_____/_____ (DD/MM/YYYY)

Has the student recently been hospitalized for treatment of this diagnosis/disability? ☐ Yes ☐ No

If yes, please indicate the most recent date range of hospitalization: _____/_____/_____ (DD/MM/YYYY) to _____/_____/_____ (DD/MM/YYYY)

If yes, has a safety plan been established, or is one required? ☐ Yes ☐ No

SECTION 9: CURRENT TREATMENT

- ☐ Individual Psychotherapy
- ☐ Group Therapy
- ☐ Complementary therapies (e.g., yoga, meditation)
- ☐ Other: _____
- ☐ Massage Therapy
- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Other: _____

Is the student currently taking medication for their symptoms? ☐ Yes ☐ No

Is the student's academic functioning restricted at certain times of the day (i.e., medication side effects, symptoms of condition, etc.)? ☐ Morning ☐ Afternoon ☐ Evening

If yes, please specify any side effects that impact the student's functioning:

_____

_____

_____

_____

SECTION 10: FUNCTIONAL LIMITATIONS

Note: Assess the functional limitations that would affect the student in post-secondary studies / the adult learning environment. Please rate the impact of the impairment caused by the disability and medication effects (if any), using the scale below:

None:	No disability-based functional limitation evident in this area.
Mild:	Minimal functional limitation evident in this area. May require some degree of academic accommodations.
Moderate:	Moderate degree of impairment that impact/interferes with academic functioning. Academic accommodations are likely required.
Severe:	Severe degree of impairment that require accommodations. May be unable to function within the academic environment with or without accommodations.
Unknown/Cannot Assess	Unable to assess or unknown at this time

Functional Limitations

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Attention/concentration	☐	☐	☐	☐	☐	
Short-term memory	☐	☐	☐	☐	☐	
Long-term memory (*please attach testing results)*	☐	☐	☐	☐	☐	
Information processing (verbal)	☐	☐	☐	☐	☐	
Information processing (written)	☐	☐	☐	☐	☐	

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Managing distractions	☐	☐	☐	☐	☐	
Managing distractions (external)	☐	☐	☐	☐	☐	
Managing emotions/stress	☐	☐	☐	☐	☐	
Executive Functioning Organization	☐	☐	☐	☐	☐	
Planning	☐	☐	☐	☐	☐	
Problem solving	☐	☐	☐	☐	☐	
Sequencing	☐	☐	☐	☐	☐	
Time management	☐	☐	☐	☐	☐	
Speaking	☐	☐	☐	☐	☐	
Mobility (sit, stand, walk)	☐	☐	☐	☐	☐	
Pain	☐	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	☐	
Handwriting	☐	☐	☐	☐	☐	
Typing/keyboarding	☐	☐	☐	☐	☐	
Other: _____ _____	☐	☐	☐	☐	☐	
Other: _____ _____	☐	☐	☐	☐	☐	
Comments: _____ _____ _____ _____						

Impact of Functional Limitations on Academic Performance

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Learn and retain course material	☐	☐	☐	☐	☐	
Orally present information	☐	☐	☐	☐	☐	
Participate in classroom settings	☐	☐	☐	☐	☐	
Participate in timed examinations	☐	☐	☐	☐	☐	

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Complete assignments (group-based)	☐	☐	☐	☐	☐	
Complete assignments (independently)	☐	☐	☐	☐	☐	
Regularly attend class/labs	☐	☐	☐	☐	☐	
Take notes	☐	☐	☐	☐	☐	
Work with others	☐	☐	☐	☐	☐	
Meet coursework deadlines	☐	☐	☐	☐	☐	
Other: _____ _____	☐	☐	☐	☐	☐	
Other: _____ _____	☐	☐	☐	☐	☐	

Do the functional limitations of the student's disability necessitate absence from class/academic activities? ☐ Yes (below) ☐ No

☐ < 1 day per mo; ☐ 2-5 days per mo; ☐ > 5 days per mo

In your opinion, is this student **able to meet the demands of a full course load?** (*15-20 hours of class, lab, or tutorial meetings per week, plus 25-30 hours of study time per week is the equivalent of 5 full course units*) ☐ Yes ☐ No

If no, please estimate the **maximum** amount of time in **hours per week** that the student should be able to spend in these activities: _____

Will the **reduced course load be required for the whole duration** of the academic program to mitigate symptoms of the condition? ☐ Yes ☐ No

Additional information (Please use this space to provide any other information about the student's disability and their functional limitations that the University of Waterloo should consider):

_____

_____

_____

_____

_____

_____

_____

_____

CERTIFICATE OF ATTENDING HEALTH CARE PRACTITIONER

Documentation completed by a relative of the patient/student will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form above.	
Practitioner Name (Please print):	**Specialty:** ☐ Psychiatrist ☐ Psychologist ☐ Family Physician ☐ Other: _____
Practitioner Signature:	**Address/Clinic Name**:
Practitioner License/Registration #:	**Phone #:** ( ) -
Affix card here or office stamp	**Fax #**: ( ) -
	Date Completed: _____/_____/_____ (DD/MM/YYYY)