

## Queen's Student Accessibility Services

Queen's University  
Côté Sharp Wellness Centre, Mitchell Hall  
69 Union Street | Kingston, ON | K7L 3N6  
613-533-2506  
<https://www.queensu.ca/studentwellness/accessibility-services/>



### Disability Verification Disability Category: **DEVELOPMENTAL DISORDER**

This form should be completed by one of the following appropriately licensed and trained professionals:  
**Psychologist, Psychiatrist, Developmental Pediatrician, Family Physician**

Please print clearly in black ink

STUDENT INFORMATION:	
Last Name: _____	Preferred/Given Name: _____
Date of Birth: _____	Student Number: _____
Queen's Net ID: _____	Phone: _____
FIELDWORK/PLACEMENTS:	
Will you be required to complete fieldwork (placements/practicums/co-op)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Type of Fieldwork: _____	
Date Fieldwork Begins: _____	
DISCLOSURE OF DIAGNOSIS:	
Note: You are <b>NOT</b> required to disclose your <i>medical diagnosis</i> in order to receive accommodations and supports. However, QSAS does require verification of the nature of your disability and, more importantly, information about how it impacts you at university. QSAS will use this information to recommend appropriate accommodations and supports for you at Queen's.	
CONFIDENTIALITY:	
Information provided to QSAS in this form, including any medical diagnosis(es), is kept <b>strictly confidential</b> . It is not shared with anyone outside of QSAS, including with other university departments, without the expressed and written consent and/or direction of the student.	
Do you consent to your medical diagnosis being identified on this form and communicated to Queen's Student Accessibility Services?	<input type="checkbox"/> YES <input type="checkbox"/> NO
RELEASE OF INFORMATION:	
I hereby authorize my Health Care Professional (HCP), who is completing and signing this form, to share information with Queen's Student Accessibility Services about my disability and its functional impacts.	
Student Signature: _____	Date: _____

Personal information is collected under the authority of the *Queen's University Royal Charter, 1841*(as amended) and will be used to provide disability-related services and accommodations for studies at university.

Student's Informed Release is done in accordance with the following sections of the Freedom of Information and Protection of Privacy Act: 41.(1) (a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), 42 (1)(c), and 42(1)(d) allowing for the disclosure of personal information.

**HEALTH CARE PROFESSIONAL:**

Queen's University is relying on, and appreciates, your detailed knowledge of this student's disability, especially how its **limitations or restrictions may impact on their learning** at university. Careful consideration should be given to the **verification of disability** and **degree of functional limitation** in the sections below.

**VERIFICATION OF DISABILITY:**

If the student consented above to disclose their medical diagnosis, please provide a clear diagnostic statement. Include DSM-5 Code diagnosis and level of severity. **Note:** Indicate any co-existing diagnoses or concurrent conditions, including DSM-5 code where applicable.

**DURATION:**

- PERMANENT:** Ongoing, will impact the student over the course of their academic career, *and* is expected to remain for their natural life
- PERMANENT, EPISODIC:** Periods of good health interrupted by periods of illness or disability, and is expected to remain for their natural life
- TEMPORARY:** Anticipated Duration \_\_\_\_/\_\_\_\_ (MM, YR) to \_\_\_\_/\_\_\_\_ (MM, YR)
- PROVISIONAL:** I am still monitoring/assessing the student.  
Assessment likely to be completed by: \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD, MM, YR)

Next Clinical Assessment Date (if applicable): \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD, MM, YR)

If **duration is unknown**, please indicate a reasonable duration for which the student should be accommodated: \_\_\_\_\_ (number of months) or which **TERM(S)**:

- FALL
- WINTER
- SPRING/SUMMER

Please Note: **Interim Academic Accommodations** may be provided during the assessment period. To extend these accommodations, updated documentation may be required for conditions still being assessed.

**ASSESSMENT INFORMATION:**

How long has the student been your patient?

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

Will you be monitoring/treating this student while they are at Queen's?  YES  NO

**CLINICAL ASSESSMENT METHODS USED. CHECK ALL THAT APPLY:**

- Clinical Assessment Date(s): \_\_\_\_\_
- Global Assessment of Functioning (GAF) or WHO-DAS Score: \_\_\_\_\_
- Psychiatric Evaluation Date(s): \_\_\_\_\_
- Neuropsychological or psycho-educational assessment Date: \_\_\_\_\_  
*Please provide a copy, including a list of tests completed and scores.*
- Behavioral Observations

**DISABILITY INFORMATION:**

Please indicate level of severity:  Mild  Moderate  Severe

Date of Onset: \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD, MM, YR)

Date of most recent assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_ Next Assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has the student been hospitalized for treatment of this diagnosis?  YES  NO

If yes, please indicate date of most recent hospitalization: \_\_\_\_/\_\_\_\_/\_\_\_\_

Does the student have a history of self-injury or injury to others?  YES  NO

Does the student have a history of seizures?  YES  NO

If yes, has a safety plan been established?  YES  NO

**CURRENT TREATMENT -Optional: (Check all that Apply)**

Psychotherapy

Behavioral Therapy

Group therapy

Occupational Therapy

Complementary therapies (e.g., yoga, meditation)

Physiotherapy

Skills Training (e.g., Social, Self-Regulation, etc.)

Other:

Is the student currently taking medication for their symptoms?  YES  NO

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

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**RESTRICTIONS AND LIMITATIONS:**

In the following section, please indicate severity of disability based on the *number and severity of symptoms/restrictions*, and their *impact on the student's functioning* in a university academic environment. Please use the following scale:

**Note: The Health Care Provider must complete this section in consultation with the student. Students should no complete this section independently without input from their Health Care Provider.**

<b>Mild:</b>	No impact, or mild impact. The student does not require academic accommodation.
<b>Moderate:</b>	Symptoms are prominent. The student will require some academic accommodation.
<b>Serious:</b>	The student has a high degree of impairment. Symptoms/restrictions markedly interferes with academic functioning. Student will require significant academic accommodation.
<b>Severe:</b>	Symptoms/restrictions so severe that student is unable to function at any level in a university academic environment, even with significant academic accommodation.

<b>Symptoms/Restrictions</b>	<b>Mild</b>	<b>Moderate</b>	<b>Serious</b>	<b>Severe</b>	<b>Comment</b>
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**PHYSICAL:**

Repetitive and Stereotypical Behavior					
Poor Coordination/ Clumsy Movements					
Headache					
Sensitivity to Tactile or Olfactory Stimuli					
Sensitivity to Visual Stimuli					
Sensitivity to Auditory Stimuli					

**SLEEP:**

Insomnia					
Poor Sleep Hygiene					
Trouble Falling Asleep					
Sleep Apnea					

**THINKING:**

Difficulty Processing Auditory Information					
Difficulty Processing Visual Information					

HCP Initial
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<i>Symptoms/Restrictions</i>	<i>Mild</i>	<i>Moderate</i>	<i>Serious</i>	<i>Severe</i>	<i>Comment</i>
Difficulty Processing Information Quickly					
Difficulty Concentrating					
Difficulty Remembering					
Difficulty Organizing/Planning					
Difficulty Reasoning & Thinking Rationally					
Difficulty Managing Time (incl. free time)					
<b>SOCIO-EMOTIONAL:</b>					
Difficulty Responding to Non-Verbal Social Cues					
Difficulty Responding to Common Social Cues					
Difficulty Understanding Personal Space					
Difficulty Self-Regulating in Daily Activities					
Difficulty Interacting with Others					
Difficulty Expressing Empathy					
Irritability					
Nervousness					
Low Motivation					
Difficulty Making Decisions					
Difficulty Managing Regular Stress					
Difficulty Managing Internal Distractions					
Difficulty Managing External Distractions					

HCP Initial

<b>COMMUNICATION:</b>					
<i>Symptoms/Restrictions</i>	<i>Mild</i>	<i>Moderate</i>	<i>Serious</i>	<i>Severe</i>	<i>Comment</i>
Difficulty Understanding Language & Emphasis					
Tone Variation					
Difficulty Understanding Humor, Metaphors, Sarcasm					
Repetitive Questions or Comments					
Speech Monotonous, Rigid, or Unusually Fast					

<b>ACTIVITIES -Optional: (Check all that Apply)</b>					
Using the same scale above, please indicate the level of impact of the student's disability and their associated symptoms/restrictions on the following activities expected of them in a university environment:					
<i>Activity</i>	<i>Mild</i>	<i>Moderate</i>	<i>Serious</i>	<i>Severe</i>	<i>Comment</i>
Attending Class					
Taking Notes					
Reading					
Writing					
Completing Exams					
Delivering Presentations					
Meeting Assignment Deadlines					
Participating in Group Activities					
Adapting to Schedule Changes					
Participating in Lab Activities					
Appropriate Classroom Participation and Behavior					
Other					
Other					

HCP Initial

**COURSE LOAD:**

Is the student's condition sufficiently stable **at this time** to sustain participation in regular university academic activities?  YES  NO

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)?  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: \_\_\_\_\_

Additional Information (Please use this space to provide any other information about the student's disability and their functional limitations that Queen's should consider in supporting the student)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HEALTH CARE PROFESSIONAL INFORMATION:**

**Name:**  
(Please PRINT)

**Facility Name and Address** (Please use Official Stamp)  
(Note: If you do not have an office stamp, please sign, date, and attach a page of your Office Letterhead)

	<b>Specialty:</b>			
	<input type="checkbox"/>	Psychiatrist	<input type="checkbox"/>	Neuropsychologist
	<input type="checkbox"/>	Family Physician	<input type="checkbox"/>	Psychologist
	<input type="checkbox"/>	Developmental Pediatrician		
<input type="checkbox"/>	Other			

<b>Health Care Professional Signature:</b>	<b>Registration/License No.:</b>

<b>Date:</b>	<b>Phone:</b>
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<b>Fax:</b>	
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HCP Initial
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