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: **BRAIN INJURY**

This form should be completed by one of the following appropriately licensed and trained professionals:
Neurologist, **Neuropsychologist**, **Psychiatrist**, **Psychologist**, **Psychological Associate**, **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)? ☐ YES ☐ NO

Type of Fieldwork: _____

Date Fieldwork Begins:

DISCLOSURE OF DIAGNOSIS:

Note: You are **NOT** required to disclose your *medical diagnosis* 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 ***strictly confidential***. 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? ☐ YES ☐ 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. Avoid phrases 'suggests', 'is indicative of', etc. NOTE: Indicate any co-existing diagnoses or concurrent conditions, indicating the 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: _____

☐ Diagnostic Imaging/Tests ☐ MRI ☐ CT ☐ EEG ☐ X-ray

☐ Neuropsychological or other formal assessment. Date: g _____
Please provide a copy, including a list of tests completed and scores.

☐ Behavioral Observations

☐ Other:

TYPE OF INJURY:

☐ **CONCUSSION** Date of Injury: _____/ _____ / _____ (DD, MM, YR)

Date of most recent assessment: Next Assessment:
_____/ _____ / _____ (DD, MM, YR) _____/ _____ / _____ (DD, MM, YR)

Has the student had previous concussions? ☐ YES ☐ NO

If yes, please indicate how many previous concussions and their approximate date(s) of occurrence:

_____

☐ **BRAIN INJURY** ☐ **OTHER** :_____

Please indicate the severity of injury:

☐ Mild ☐ Moderate ☐ Severe

Date of Injury: _____ Date of Diagnosis: _____

CURRENT TREATMENT - Optional: (Check all that Apply)

☐ Chiropractic Therapy ☐ Massage Therapy
☐ Neuropsychological Assessment/Counselling ☐ Occupational Therapy
☐ Outpatient ABI Treatment ☐ Physiotherapy
☐ Psychotherapy ☐ Speech/Language Therapy
☐ 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?

RESTRICTIONS AND LIMITATIONS:
NOTE: The Health Care Provider must complete this section in consultation with the student. Students should not complete this section independently without input from their Health Care Provider.
In the following section, please check the severity of disability based on the *number of and severity of symptoms/restrictions*, and their *impact on the student's functioning* in a university academic environment. Please use the following scale: ***Mild*:** No impact, or mild impact. The student does not require academic accommodation. ***Moderate*:** Symptoms are prominent. The student will require some academic accommodation. ***Serious*:** The student has a high degree of impairment. Symptoms/restrictions markedly interferes with academic functioning. Student will require significant academic accommodation. ***Severe*:** Symptoms/restrictions so severe that student is unable to function at any level in a university academic environment, even with significant academic accommodation.

Symptoms/Restrictions	*Mild*	*Moderate*	*Serious*	*Severe*	*Comment*
PHYSICAL:					
Dizziness	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	
Headache	☐	☐	☐	☐	
Nausea	☐	☐	☐	☐	
Sensitivity to Light	☐	☐	☐	☐	
Sensitivity to Noise	☐	☐	☐	☐	
Eye Fatigue/Strain After ____ Minutes	☐	☐	☐	☐	
Restricted Ability to View Screen	☐	☐	☐	☐	
Restricted Ability to Read Print (Paper)	☐	☐	☐	☐	
Visual/Perceptual Problems	☐	☐	☐	☐	
Vomiting	☐	☐	☐	☐	

Symptoms/Restrictions	*Mild*	*Moderate*	*Serious*	*Severe*	*Comment*
SLEEP:					
Drowsiness	☐	☐	☐	☐	
Sleeping Less than Usual	☐	☐	☐	☐	
Sleeping More than Usual	☐	☐	✔	✔	
Trouble Falling Asleep	☐	☐	☐	☐	
THINKING:					
Feeling Mentally Foggy	☐	☐	☐	☐	
Feeling Slowed Down	☐	☐	☐	☐	
Difficulty Concentrating	☐	☐	☐	☐	
Difficulty Remembering	☐	☐	☐	☐	
Difficulty Processing Information	☐	☐	☐	☐	
Difficulty Reasoning and Thinking Rationally	☐	☐	☐	☐	
Difficulty Organizing/Planning	☐	☐	☐	☐	
SOCIO-EMOTIONAL:					
Irritability	☐	☐	☐	☐	
Depressed/Sadness	☐	☐	☐	☐	
Nervousness	☐	☐	☐	☐	
Difficulty Managing Regular Stress	☐	☐	☐	☐	
Difficulty Managing Internal Distractions	☐	☐	☐	☐	
Difficulty Managing External Distractions	☐	☐	☐	☐	

ACTIVITIES – Optional:					
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:					
Activity	***Mild***	***Moderate***	***Serious***	***Severe***	***Comment***
Attending Class	☐	☐	☐	☐	
Taking Notes	☐	☐	☐	☐	
Reading	☐	☐	☐	☐	
Writing	☐	☐	☐	☐	
Completing Exams	☐	☐	☐	☐	
Delivering Presentations	☐	☐	☐	☐	
Meeting Assignment Deadlines	☐	☐	☐	☐	
Participating in Group Activities	☐	☐	☐	☐	
Other	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Course Load:				
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)				
	Specialty:			
	☐	**Neurologist**	☐	**Neuropsychologist**
	☐	**Psychiatrist**	☐	**Psychologist**
	☐	**Psychological Associate**	☐	**Family Physician**
	☐	**Other**		
Health Care Professional Signature:		**Registration/License No.:**		
Date:		**Phone:**		
Fax:		**Email:**		