Glendon Accessibility, Well-Being and Counselling Centre
Mental Health Medical Documentation

Glendon Accessibility, Well-Being, and Counselling Centre

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<u>This section to be completed and signed by the student PRIOR TO asking a health care professional to complete the Medical Documentation Form</u>

Consistent with the Ontario Human Rights Commission's Policy on preventing discrimination based on mental health disabilities and addictions and the York University Documentation Guidelines for Students with Mental Health Accessibility Services, you are not required to disclose your mental health disability diagnosis in order to register with Mental Health Accessibility Services and to receive academic accommodation. The Ontario Human Rights Commission recognizes that Accessibility Services Offices have expertise in dealing with accommodation issues in the academic environment, and as such, can play a vital role in assisting with the accommodation process. If you wish to, you may voluntarily disclose your diagnosis to Glendon Accessibility Services.

Providing your diagnosis may be required to establish eligibility for certain federally or provincially-funded bursaries and grants and privately funded external scholarships and financial awards. This Form can be used to establish eligibility for such financial assistance, provided you have consented to the disclosure of your mental health diagnosis.

If you choose to consent to the disclosure of your mental health diagnosis, you must check the box below. Your consent will allow your Health Care Practitioner to complete the relevant section of the Form.

☐ I consent to disclose the diagnosis of my mental health disability

_____
Signature of Student:

Please Print:

Student's Last Name: _____
Student's First Name: _____
Date of Birth(mm/dd/yyyy): _____
Student Number: _____
Address: _____
_____
Phone (Home/Cell): _____
Email Address: _____

Dear Health Care Practitioner,

You have been asked by a student who wishes to register with Accessibility Services at Glendon Campus/York University to complete the enclosed documentation. Accessibility Services is an educational support program for students who **require academic accommodation for a permanent or temporary mental health disability.** Interim accommodations may be provided for students who are in the process of being assessed for a mental health disability.

As you know, the post-secondary environment involves taking examinations, doing research, completing assignments, and assuming responsibility for one's higher education pursuits. The purpose of the Accessibility Services medical/psychological documentation is to enable Accessbility Counsellors to recommend appropriate academic accommodations for students with mental health disabilities who experience functional restrictions and limitations which affect their academic performance.

We are accountable under the Ontario *Human Rights Code* and *York's Senate Policy on Accommodating Students with Disabilities.* These guidelines help us provide academic accommodations that level the playing field for students with disabilities without creating an unfair advantage or undermining academic integrity. **We rely on your detailed knowledge of this student's disability, including a list of the functional limitations and restrictions that may impact their education together with your recommendations for appropriate academic accommodations.**

Thank you for helping to reduce barriers for students with disabilities while upholding the academic standards of the university.

This form must be completed by a licensed medical practitioner or registered psychologist.

Functional Limitations Assessment Form for Post-Secondary Students with a Mental Health Disability

NOTE: The following criterion must be met for the determination of a disability:

The student experiences functional limitations due to a mental health condition that impairs the student's academic functioning while pursuing post-secondary studies.

Please check one box on the left:

☐ I confirm that this student has a disability based on a diagnosed mental health condition according to the criterion outlined above.

Or

☐ I confirm that I am in the process of monitoring and assessing the student's mental health condition to determine a diagnosis and this assessment is likely to be completed by _____.
Date

If the student has consented to disclosure of specific diagnosis to Accessibility Services (as indicated by their singnature on page 1), please provide the diagnosis AND DSM-V code, as applicable

_____

_____

_____

Duration of Disability:

Complete 1 OR 2 OR 3

1. This student has a **permanent disability** (*the mental health disability is expected to be lifelong)* with symptoms that are:

   ☐ continuous OR
   ☐ recurrent/episodic

2. This student has a **temporary disability** with symptoms that are:

   ☐ continuous OR
   ☐ recurrent/episodic
   Accommodations to be provided from _____ to _____*

3. ☐ This student is **being assessed** to determine a diagnosis.*

* Updated documentation will be required by MHDS to continue providing academic accommodation.

_____

Medication

If this student has been prescribed medication for this condition, when is the medication likely to have a negative effect on their academic functioning? (Check all that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ N/A

_____

Functional Limitations

Using the following scale, please rate the impact of the impairment caused by the disability as well as possible medication effects (if any) on the areas of functioning below.

1	2	3	4	5
Within normal limits No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area	 Unable to assess or unknown at this time

A. Cognitive Skills/Abilities

Attention/Concentration	☐1	☐2	☐3	☐4	☐5
Short-Term Memory	☐1	☐2	☐3	☐4	☐5
Long-Term Memory	☐1	☐2	☐3	☐4	☐5
Information Processing	☐1	☐2	☐3	☐4	☐5
Ability to Manage Distractions	☐1	☐2	☐3	☐4	☐5
Executive Functioning Planning, Organizing, Problem solving, Sequencing, Time-management	☐1	☐2	☐3	☐4	☐5
Ability to Meet Assignment Deadlines	☐1	☐2	☐3	☐4	☐5

Ability to Take Notes During Class Lectures ☐1 ☐2 ☐3 ☐4 ☐5

Other ☐1 ☐2 ☐3 ☐4 ☐5

Please describe:

Comments: *Please elaborate on any of the areas above that need further explanation.*

1	2	3	4	5
Within normal limits No functional limitation evident in this area	**Mild or slight** Functional limitation evident in this area	**Moderate** Functional limitation evident in this area	**Severe** Functional limitation evident in this area	Unable to assess or unknown at this time

B. Social-Emotional Behavioural Functioning

Ability to Participate in Group Work Situations ☐1 ☐2 ☐3 ☐4 ☐5

Ability to Participate in Classroom Settings ☐1 ☐2 ☐3 ☐4 ☐5

Ability to Deliver Oral Presentations ☐1 ☐2 ☐3 ☐4 ☐5

Ability to Manage Emotions During Academic Evaluations ☐1 ☐2 ☐3 ☐4 ☐5

Comments: *Please elaborate on any of the areas above that need further explanation:*

Please list any additional functional limitations that may impair the student's academic functioning in the post-secondary setting:

_____

_____

How did you arrive at this assessment? Check all relevant items below:

☐ Structured or unstructured interviews with student
☐ Interviews with other persons (parent, teacher, therapist)
☐ Behavioral observations
☐ Psycho-educational or Neuropsychological Testing
☐ Other (please specify): _____

RECOMMENDED ACADEMIC ACCOMMODATIONS:

Based on the functional limitations that you identified above, do you have recommendations for specific academic accommodations (e.g. reduced course load, extended time to complete tests/ exams, flexibility in assignment due dates, assistive technology, note-taking supports, etc.)?

_____

_____

_____

Student's strengths:

_____

_____

_____

_____

Date Completed (mm/dd/yyyy): _____

Practitioner's Name (please print): _____

Practitioner's Signature: _____

Medical Practitioner's License Number: _____

Registered Psychologist's Registration Number: _____

Name/Address/Phone Number →

Please use office stamp as well as signature

Return completed form to Glendon Accessibility, Well-Being an Counselling Centre or fax this form to: 416-440-9237, Accessibility Services, Glendon Campus, Attention: Sylvie Aubin

Student Consent

Completion of this section is voluntary; however, if you elect not to provide your consent at this time and in the event that further information is required there may be delays in the provision of your accommodation.

I give consent to Glendon Accessibility, Well-Being and Counselling Centre to contact my medical practitioner or registered psychologist to discuss the information provided in this document if necessary to clarify the information provided regarding functional restrictions and limitations or if there are questions about complex academic accommodation.

Student's Signature: _____

Date: (mm/dd/yyyy): _____

****Note to student:** If you have other relevant documentation, you may include copies of it with this registration package. These additional documents are not intended to replace the MHDS registration package. Please note - additional documentation may be requested