Georgian

# MEDICAL INFORMATION REQUEST FORM

**Attention Health Care Practitioner:** This form will be used as part of the criteria to determine the student's eligibility to receive academic accommodations and support services at Georgian College.

**Confidentiality:** The information contained in this form is kept strictly confidential and is only used to help determine accommodations and supports. Collection, use and disclosure of this information is subject to all applicable privacy legislation.

## SECTION A: To be completed by the student

First Name: ______________________ Last Name: ______________________

Phone Number: ( ) ______________________ Student ID #: ______________________

Date of Birth (dd/mm/yyyy): ____/____/______ Email: ______________________

**Student consent to release of information pursuant to the Personal Health Information Protection Act, 2004** (PHIPA)

I, ______________________ consent to the disclosure of my personal health information by the regulated health care professional for the purpose of confirming my need for an academic accommodation. Under the Ontario Human Rights Code, you are not required to disclose a specific diagnosis to access academic accommodations.

Check One (optional):
- ☐ I give consent for a diagnosis to be provided
- ☐ I do not give consent for a diagnosis to be provided

______________________ Student Signature ______________________ Date

## SECTION B: To be completed by Regulated Health Care Professional

*Permanent Disability Definition: For the purposes of OSAP, 'permanent disability' is defined as a functional limitation that is caused by a physical or mental impairment that restricts ability to perform the daily activities necessary to participate in studies at a post-secondary level or in the labour force, and that is expected to remain with the individual for their expected life.* ***Please note:*** A confirmation of disability is required to access some government financial aid programs for students with disabilities.

**Select the appropriate option:**

- ☐ This student has a **permanent** disability Yes ☐ No ☐
- ☐ This student has a **temporary** disability Yes ☐ No ☐
- ☐ Interim accommodations to be provided until [date]* ______________________
- ☐ This student is being **monitored** to determine a diagnosis
  Interim accommodations to be provided until [date]* ______________________

* Updated documentation will be required after this date

If consent to disclose diagnosis was provided, please complete the following, using DSM-5 criteria when applicable:

The student has the following diagnosis: ____________________________________________

Do you consider this person in stable condition and capable of managing academic stress? Yes ☐ No ☐
Please comment:______________________________________________________________________________

**Functional Impact:**
Please indicate challenges that may impair the student's academic functioning at the post-secondary level.
If more space is required, please attach.

- ☐ Concentration/Attention/Focus______________________________________________________
- ☐ Memory______________________________________________________________________
- ☐ Mobility______________________________________________________________________
- ☐ Fatigue______________________________________________________________________
- ☐ Chronic Pain__________________________________________________________________
- ☐ Learning Difficulties___________________________________________________________
- ☐ Social/Emotional Difficulties_____________________________________________________
- ☐ Other_______________________________________________________________________

**Medications:**
Has the student been prescribed medication that may impact academic functioning? ☐ Yes ☐ No
If yes, please describe impact: ________________________________________________________

_____________________________________________________________________________________

**SECTION C:** Certificate of Regulated Health Care Professional

| License/Registration Number: | Email: |
| --- | --- |
| Phone: | Fax: |

**Office Stamp**

**Regulated Health Care Professional**

- ☐ Physician – Family
- ☐ Physician – Other: ______________________
- ☐ Psychologist/Psychological Associate
- ☐ Other: ______________________

I ______________________________ am a legally qualified health care professional and this report contains my clinical assessment and considered opinion at this time, within the scope of my practice.

______________________________ ______________________________
Signature Date