Advising & Access Services Centre
MEDICAL ASSESSMENT FORM
For Students Requesting Accommodation for Reason of Disability

Dalhousie University’s Advising & Access Services Centre requires completion of this form by an appropriately qualified medical assessor/practitioner in order to assess eligibility for accommodation, and, to determine an accommodation plan. All medical documentation received by the Advising & Access Services Centre will be kept confidentially on file.

STUDENT:
• Please complete this form with your medical assessor/practitioner. The student is responsible for any costs associated with this form’s completion. The student must ensure ‘name’ and ‘Dalhousie Student ID #’ are clearly printed at the top of each page.
• The following information must be clearly stated: diagnosis of the disability, a description of the functional limitations as they pertain to the academic learning and living environment, and suggestions (if any) for academic and/or non-academic accommodations.

MEDICAL ASSESSOR /PRACTITIONER:
• This medical assessment form will help determine accommodation plans for students with disabilities at Dalhousie University. Accommodations are meant to reduce or remove barriers for students to participate in, and have access to, University academic programs, activities, facilities and services.
• This form would not be appropriate for students with a diagnosed Learning Disability, or students who have been diagnosed with ADHD as part of a current psycho-educational assessment.
• Please complete all sections relevant to the student’s disability.
• Please sign and date where indicated on this form.

COMPLETED FORMS MAY BE MAILED, FAXED OR DELIVERED TO:
Advising & Access Services Centre
Dalhousie University
PO Box 15000
Killam G28
Halifax, Nova Scotia B3H 4R2

Tel: 902.494.2836
Fax: 902.494.6797
PART A: PERSONAL INFORMATION - Student must fill out this section

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Student ID#</th>
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<tr>
<th>Province/Country</th>
<th>Home phone</th>
<th>Cell Phone</th>
<th>Date: dd/mm/yyyy</th>
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Student Authorization for Release of Medical Information

I hereby authorize the information on this form to be released to Advising and Access Services Centre.

Student Signature __________________________ Date __________________________
Witness Signature __________________________ Date __________________________
Witness Printed Name __________________________ Date __________________________

PART B: MEDICAL DOCUMENTATION: to be completed by appropriate practitioner

1. Diagnosis:
   - [ ] ADHD
   - [ ] Vision Loss/Blind/Low Vision Disability
   - [ ] Hearing Loss/Deaf/Hard of Hearing Disability
   - [ ] Mental Health Disability
   - [ ] Physical/Mobility Disability
   - [ ] Chronic Health Disability
   - [ ] Autism Spectrum
   - [ ] Other Diagnosed Disability ____________________________________________________

2. Date of Diagnosis: __________________________

3. Last contact with the student (prior to receiving this form): __________________________

4. If student is taking medication(s), is there an impact, and/or adverse side effect(s) we should we aware of as it relates to access?

_________________________________________________________________________________________
5. If the student is currently undergoing other medical treatment, please describe how the treatment might affect the student academically.

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

6. Please describe how this medical condition may result in limitations/barriers in academic or daily living settings at university (i.e. problems sitting for long periods of time; unable to type for more than ten minutes; unable to walk specific distances without fatigue; difficulty maintaining attention during a 50-80 minute lecture; number of days this disability may require the student to be absent from class each month; meeting the demands of a full course load of three courses/term or more.)

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

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______________________________________________________________________________________________________________

7. If required does the student have access to community supports? If not, what on-campus support services would you recommend to the student? On-campus supports could include: Counselling; Physiotherapy; Occupational Therapy; Access to a Fitness Facility; Physician or Nurse Practitioner.

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________
PART C: RECOMMENDED ACCOMMODATIONS

Please select only the accommodations that are applicable to the student’s diagnosis and functional limitations. Advising and Access Services Centre will assess recommendations against the academic requirements for a course and/or program, and other contexts prior to making a determination.

Exam Accommodations

☐ Extended time on exams. Specify the rationale/purpose for this accommodation: (i.e. cognitive affects)
_____________________________________________________________________________________

☐ Stop Time Breaks (used for stress reduction; medical procedures; nutrition breaks; etc.)

☐ Write in distraction-reduced environment

☐ Reader

☐ Scribe

☐ Use of computer

☐ Use of disability-specific assistive technology

☐ Other _________________________________________________________________

Classroom Accommodations

☐ Note taking support (i.e. peer note taker, recording lectures, assistive technology)

☐ Visually presented information verbalized

☐ Frequency Modulation system

☐ Sign language interpretation

☐ Enlarged handouts (size recommendation) ______________________________________

☐ Assistive Technology _______________________________________________________

Other Accommodations (including living in residence) ______________________________________
____________________________________________________________________________________
____________________________________________________________________________________

NOTE: this is not an inclusive list. Other supports can be discussed with the student and advisor.

______________________________  ____________________________
Signature of medical assessor/practitioner: Date:

______________________________
Print name, title, and Location:

______________________________
Telephone: