NIPISSING
UNIVERSITY
STUDENT DEVELOPMENT AND SERVICES

STUDENT INFORMED CONSENT FOR MENTAL HEALTH AND ADHD DOCUMENTATION

This section to be completed by the student PRIOR TO asking a health care professional to complete the following Medical Documentation Form. Attach this form to Medical Documentation Form and provide both to health care practitioner.

Please Print:

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

Consistent with the Ontario Human Rights Commission, Nipissing University does not require you to disclose your diagnosis in order to register with Student Accessibility Services (SAS) and to receive academic accommodation. Although not required, a diagnosis is used by a relevantly trained disability service professional in Student Accessibility Services to infer and anticipate barriers and accommodation needs in an academic setting, where relevant information is not otherwise available.

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 diagnosis.

If you decide to disclose your diagnosis, please note that this information will kept strictly confidential. Student Accessibility Services will not share this information with anyone, including your instructors, without your explicit and written consent.

If you choose to consent to the disclosure of your 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 disability.

_____ _____
Signature of Student Date

_____
Please Print Name

Student Accessibility Services - Nipissing University
100 College Drive, Box 5002, North Bay, ON, Canada P1B 8L7
Tel: 705.474.3450 ext. 4362 | Fax: 705.495.2850 | TTY: 877.688.5507

DOCUMENTATION OF MENTAL HEALTH DISABILITIES AND ADHD

Student Name: _____ Date of Birth: _____/_____/_____ (mm/dd/yyyy)

Dear Healthcare Practitioner,

This student is requesting disability-related supports and accommodations while studying at Nipissing University. The student is required to provide the University with documentation that is:

A. To be completed by a **regulated healthcare professional who has knowledge of the patient's history and is licensed to diagnose and treat mental health disorders and/or ADHD**.

B. All sections of the form must be completed fully and objectively to ensure **accurate assessment of the student's disability-related needs**, which may have significant implications on access to support services and academic accommodations in university, or entitlement to a range of benefits including government funding.

C. Careful consideration should be given to the **statement of disability and relevant functional limitations**. Please note, a diagnosis is requested but not required for students to receive academic accommodations; however, if diagnosis is not provided, functional limitations must be fully described and additional information may be requested in order to determine appropriate accommodation and support. **We rely on your detailed knowledge of this student's disability and functional limitations to assist in the planning of appropriate accommodations through Student Accessibility Services.**

Diagnostic Statement (see requirement C above):

State your DSM diagnosis for this student *(to be provided with student's consent)*:

Dx:_____

Statement of Disability (see requirements B & C above):

In my professional opinion, I can confirm the student has a formally diagnosed mental health disability or ADHD, as follows (place checkmark on the line to indicate):

☐ **Permanent disability** with ongoing symptoms:

□ Chronic (ongoing symptoms for the duration of natural life)

□ Acute (recurring episodes with relatively symptom-free periods of remission)

☐ **Temporary disability** (*for mental health only*) with anticipated duration of:_____

☐ This student is being monitored and assessed to determine a diagnosis.

DETAILED EVALUATION

1. Date the diagnosis was first established, if known: _____
2. How long have you known this student: _____
3. Please evaluate the level of functional limitation **specific to the university academic environment** in the following areas.

Areas of functioning in academic environment:	**No Impact**	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Don't Know**
Attention and concentration					
Memory					
Cognitive processing of information					
Rational thinking and reasoning					
Social Interactions					
Managing internal distractions					
Managing external distractions					
Managing coursework in full time studies					
Timely completion of tasks and meeting deadlines					
Regular participation and attendance					
Self-regulation in daily activities					
Stress management					
Ability to take notes during class/lectures					
Ability to manage emotions during academic evaluation					
Limited functioning at certain times of day (please specify):					
Other (please specify):					

4. Is this student currently taking medication(s) for their symptoms? YES ☐ NO ☐
   If yes, describe the medication's effect on ability to complete academic activities, if applicable:

5. Based on the functional limitations, can the student sustain full time course load (4 or 5 courses per term)? Yes ☐ No, a reduced course load is recommended ☐

6. Do you consider the student to be in stable condition and capable of sustaining normal academic stress with appropriate supports, including practicum/fieldwork (if applicable)?

7. Is the student involved in any other (i.e., non-pharmacological) treatment for their symptoms?

8. Please provide any additional information that may assist us in determining appropriate accommodations and support services.

9. **For ADHD**: Has the student undergone a psychological, neuropsychological, or psychoeducational assessment*? (Please note that this form may not be sufficient to support access to a full range of disability services (e.g. Bursary for Students with Disabilities) - a full psychoeducational assessment may be required.)*

   ☐ Yes, Completed by: _____ Date: _____ ☐ No

10. While this student is enrolled at the University, will you be monitoring him/her on a regular basis?

    ☐ Yes, every: _____

    ☐ No, this student will be monitored by: _____

CERTIFICATE OF ASSESSING PROFESSIONAL

Please specify type of practitioner:

- ☐ Psychologist
- ☐ Psychiatrist
- ☐ General Practitioner
- ☐ Other (please specify:_____

I hereby certify that I provided health care services to, _____, a student at Nipissing University, on [date(s)], _____. I am providing the above information for use by the University in assessing what academic accommodation, if any, should be given to this student. I understand that I may be contacted by the University to verify this information, but will not be requested to provide further information without the consent of the student.

Name (please print):_____ Registration Number:_____

Signature:_____ Date:_____

Name/Address/Phone Number:
Please use office stamp or attach business card