Paul Menton Centre for Students with Disabilities
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DOCUMENTATION OF AUTISM SPECTRUM DISORDER

Student's Name: _____ **Date of Birth** (YYYY-MM-DD) _____

PART A: INFORMED CONSENT (To be completed by the student)

I authorize Dr._____ (full name) to release this form and provide other information relevant for provision of disability supports and services at the Paul Menton Centre for Students with Disabilities.

Date (YYYY-MM-DD) _____ Student Signature : _____

Student's Informed Release is done in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information

PART B: To be completed by a regulated health care professional

What are the purposes of this documentation?

- Confirm the presence of a formally diagnosed disability
- Identify functional limitations or impairments experienced in the university academic setting
- Information will be used to determine accommodations and support services appropriate to the university setting including eligibility to a range of benefits such as access to government funding.

Who can complete this form?

- To be completed by a **registered psychologist, psychiatrist, other relevantly trained medical doctor in the treatment of ASD or the student's family physician.**

How to complete this form?

- All sections of the form **to be completed carefully and objectively by the student's regulated health care practitioner** for an accurate assessment of the student's disability-related needs.

Statement of Disability

DSM-5 diagnosis: _____

Specify current severity: _____

Date of diagnosis (YYYY-MM-DD) _____

Please check one of the following two statements:

_____ Not a disability in the current academic setting.

_____ Permanent disability that is expected to remain with the student throughout their natural life.

Assessment of Functional Impairments

Based on your professional opinion, please **describe and indicate the degree of impact** of each of the following areas of functional impairment as they relate to participation in the university setting.

	No impact	Mild impact	Moderate impact	Severe impact	Don't Know
Attention and concentration	☐	☐	☐	☐	☐
Processing speed	☐	☐	☐	☐	☐
Communication/ language skills	☐	☐	☐	☐	☐
Organization and time management	☐	☐	☐	☐	☐
Timely completion of tasks	☐	☐	☐	☐	☐
Group projects	☐	☐	☐	☐	☐
Sensitivity to environmental conditions	☐	☐	☐	☐	☐
Oral participation	☐	☐	☐	☐	☐
Adaptation to scheduling changes	☐	☐	☐	☐	☐
Personal hygiene	☐	☐	☐	☐	☐
Social interactions	☐	☐	☐	☐	☐
Activities of daily living (If living away from home)	☐	☐	☐	☐	☐
Other (please specify): _____	☐	☐	☐	☐	☐

Academic Workload

- **Undergraduate:** A minimum of 4 to 5 courses per term is typically considered full-time.
- **Graduate:** A minimum of 2 courses per term is typically considered full-time.

Do you think the student is able to maintain full-time course load at university? Yes ☐ No ☐

If no, how many courses? ___

Do you consider the student to be in stable condition and capable of sustaining normal academic stress with appropriate accommodations and supports? Yes ☐ No ☐

Additional Information

How long have you been treating the student? _____

Will you be monitoring the student on a regular basis?

☐ Yes, every (indicate months or weeks between sessions) _____.

☐ No, this student will be followed by (health practionner's name) _____.

Please note any relevant multiple diagnoses or concurrent conditions:

_____

If the student has been prescribed medication for this condition, can you specify current side effects that may impair the student's academic performance?

_____

Please note diagnosis of coexisting conditions:

_____

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

_____

Certificate of Attending Registered/Certified Health Professional

I hereby certify that I provided health care services to, _____, a student at Carleton University. I am providing the above information for use by the University in assessing what academic accommodations, if any, should be offered to the student. I understand I may be contacted by the student's PMC coordinator to verify this information, but will not be requested to provide further information without the consent of the student.

Name: _____ Registration Number: _____

Signature:_____ Date (YYYY-MM-DD) _____

Address: _____

Telephone:_____ Fax:_____ Email:_____

Stamp or business card here

The personal information requested on this form is collected in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA), R.S.O. 1990, c.F.31 and the Personal Health Information Protection Act (PHIPA), 2004 SO 2004,c.3 as amended. The information provided will not be used for any purposes other than those stated upon this form unless the applicant provides express written consent. Should you have any questions concerning your personal information please contact the Privacy Office at phone: (613) 520-2600 ext. 2047, e-mail University.Privacy.Office@carleton.ca or mail: 607 Robertson Hall Carleton University 1125 Colonel By Drive, Ottawa Ontario K1S 5B6. Carleton University is fully compliant with FIPPA and PHIPA and endeavors at all times to treat your personal information in accordance with the law.