PMC Paul Menton Centre
CARLETON UNIVERSITY

Student Informed Consent for Mental Health Disability Documentation

Dear Student,

The attached documentation form for a mental health disability is used to gather information for the purposes of:

- Confirmation of formally diagnosed mental health disability either permanent or temporary.
- Evaluation of functional limitations in the university academic setting and determining appropriate accommodation and support.
- Obtaining additional information relevant to your mental healthdisability and providing accommodation and support.

The Paul Menton Centre at Carleton University will use the information provided to assist with determining appropriate academic accommodations and support services.

You are not required to disclose your mental health diagnosis in order to receive accommodation or support. Should you choose not to disclose the specific DSM diagnosis on the attached form, please inform your doctor prior to the completion of the documentation form. Please note, a diagnosis is used by a relevantly trained disability service professional in the Paul Menton Centre to infer and anticipate barriers and accommodation needs in academic setting, where relevant information is not otherwise available.

If the information on the documentation form is not sufficient to determine appropriate academic accommodations, you may be referred for an internal evaluation of functional limitations by a registered psychologist at Carleton University and/or asked to provide further information from your treating health professionals.

The information obtained on the documentation form may need to be updated periodically to ensure your disability documentation is current and relevant to your needs.

The information provided will be treated confidentially by the Paul Menton Centre, in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA) and Personal Health Information Protection Act (PHIPA). The information provided will be kept in confidence, used for the purposes described above and disclosed internally only on a limited need to know basis.

If you have any questions regarding your documentation of mental health disability, please contact the Paul Menton Centre. Remember to bring this letter and the completed documentation form to your appointment at the Paul Menton Centre.

I confirm that I have read and understood the above information. I _____ hereby authorize the physicians, health care practitioners, hospitals and other institutions involved in treatment or assessment of my current illness or disability, to disclose information regarding my current illness or disability to the Paul Menton Centre at Carleton University. Information to be disclosed will be limited to information that relates directly to and is necessary for achieving the purposes, as described above.

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

Paul Menton Centre for Students with Disabilities
500 University Centre, 1125 Colonel By Drive
Ottawa, ON, Canada K1S 5B6
Tel: (613) 520-6608 Fax: (613) 520-3995
Web: carleton.ca/pmc Email: pmc@carleton.ca

DOCUMENTATION OF MENTAL HEALTH DISABILITY

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

Evaluation Requirements

A. To be completed by an appropriate **regulated mental health professional who has knowledge of the patient's history and is licensed to diagnose and treat mental health disorders**.

B. At the discretion of the PMC, documentation from **other regulated mental health professionals** may be accepted for the purpose of establishing **temporary/interim** disability services and accommodations.

C. 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.

D. Careful consideration should be given to the **statement of disability and relevant functional limitations**. Please note, the student is not required to provide the DSM diagnosis to receive accommodation and support. 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. **If you are unable to provide such information, the student may be referred for an internal assessment of functional limitations.**

Statement of Disability

Diagnostic Statement (see requirement D above): State your DSM diagnosis for this this student (to be provided only with student's consent): _____

Date of diagnosis (YYYY-MM-DD) _____

Please check one of the following three statements:

☐ Temporary disability with anticipated duration from (YYYY-MM-DD) _____ to (YYYY-MM) _____

☐ Permanent disability that is expected to be remain with the student throughout their natural life

☐ Chronic disability that is expected to have an impact on the duration of the student's post-secondary studies.

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	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐
Limited functioning at certain times of day (please specify): _____	☐	☐	☐	☐	☐
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? _____

Please note any relevant multiple diagnoses or concurrent conditions:

_____

Will you be monitoring the student on a regular basis?

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

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

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

_____

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.

Please specify type of practitioner: _____

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.