Paul Menton Centre for Students with Disabilities
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DOCUMENTATION OF ACQUIRED BRAIN INJURY

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

PART A: Student's 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.

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

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 **Sports Medicine Physician, Neuropsychologist or psychologist, or a treating Family Physician**. The professional has knowledge of the patient's history and is licensed to diagnose and treat acquired brain injuries.

Statement of Disability

Diagnosis: _____ 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) _____

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

☐ 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.

Physical	No impact	Mild impact	Moderate impact	Severe impact	Don't Know
Sensitivity to lights	☐	☐	☐	☐	☐
Sensitivity to noise	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐
Visual-perceptual problems	☐	☐	☐	☐	☐

Expected duration of above cluster:

Less than four weeks ☐ School term ☐ Year ☐ Permanent ☐ Unknown ☐

Behavioural/Emotional	No impact	Mild impact	Moderate impact	Severe impact	Don't Know
Drowsiness					
Fatigue/lethargy	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	☐

Expected duration of above cluster:

Less than four weeks ☐ School term ☐ Year ☐ Permanent ☐ Unknown ☐

Cognitive	No impact	Mild impact	Moderate impact	Severe impact	Don't Know
Feeling "slowed down"	☐	☐	☐	☐	☐
Feeling "in a fog" or "daze"	☐	☐	☐	☐	☐
Difficulty concentrating	☐	☐	☐	☐	☐
Difficulty remembering	☐	☐	☐	☐	☐
Difficulty processing information	☐	☐	☐	☐	☐
Difficulty organizing	☐	☐	☐	☐	☐
Limited functioning at certain times of day (please specify):	☐	☐	☐	☐	☐

Expected duration of above cluster:

Less than four weeks ☐ School term ☐ Year ☐ Permanent ☐ Unknown ☐

Other symptoms	No impact	Mild impact	Moderate impact	Severe impact	Don't Know
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐

Expected duration of **Other symptom 1**: < 4 weeks ☐ Term ☐ Y ear ☐ Permanent ☐ Unknown ☐

Expected duration of **Other symptom 2**: < 4 weeks ☐ Term ☐ Year ☐ Permanent ☐ Unknown ☐

Expected duration of **Other symptom 3**: < 4 weeks ☐ Term ☐ Year ☐ Permanent ☐ Unknown ☐

Expected duration of **Other symptom 4**: < 4 weeks ☐ Term ☐ Year ☐ Permanent ☐ Unknown ☐

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? _____

Has the student had neuropsychological testing? Yes ☐ No ☐

How many head injuries has the student had? _____

Does the student have limited functioning at certain times of the day? Please check all that apply:

Morning ☐ Afternoon ☐ Evening ☐

Please note any relevant multiple diagnoses or concurrent conditions:

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 practitioner's name): _____

Does the student require specialized equipment, adaptive technology, ergonomic furniture or transportation during the academic year? If yes, please specify:

Please list any other treatments or therapies the student is receiving:

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: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

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

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.