Lambton College | Accessibility Centre

MEDICAL INFORMATION REQUEST FORM (MIRF)

Dear Regulated Health Professional,

You have been asked to complete this form by a student who wishes to register with the Accessibility Centre (AC) at Lambton College. The AC provides academic accommodations and educational support services for Lambton College students with documented disabilities. Our goal is to provide necessary academic accommodations to equalize the opportunity for students to access curriculum and meet essential course/program requirements while maintaining academic integrity. This service is provided in accordance with the *Canadian Charter of Human Rights & Freedoms*, the Ontario Human Rights Commission's *Policy on Accessible Education for Students with Disabilities* (2018) and *Guidelines on Accessible Education* (2004), the *Ontario Human Rights Code,* and Lambton College Policy 2000-9-1.

The purpose of this form is to provide a consistent approach for Regulated Health Professionals to document the functional limitations that a student with a disability may experience. **Your detailed knowledge of this student's disability, including a description of the current functional impairments that may impact his/her ability to meet essential course/program requirements, will help the AC determine appropriate academic accommodations for this student**. Information provided should clearly relate to accommodation planning for studies, assignments, research, and assessments at the post-secondary level.

This form can be used by students with **Permanent** or **Temporary** mental health/medical disability with symptoms that are continuous or episodic, or those in the process of being assessed for a disability. Students who are in the process of being assessed for a mental health/medical disability may be eligible for *Interim Academic Accommodation* support.

Under Ontario's *Human Rights Code*, it is not a requirement to specify the **diagnosis** in this form in order to access academic accommodation at Lambton College. In these instances, the functional limitations of the disability must be thoroughly described. Students are asked to indicate if they provide consent to release diagnosis on page 2 of this document. There may be some instances where a diagnosis is required to establish eligibility for specific student supports (for example, Ministry funding).

The information provided on this form is an essential part of the criteria to assess and implement accommodations to reduce/eliminate barriers accessibility students may face in achieving program learning outcomes. It may also be used to determine eligibility for government grants/ bursaries. Information on this form is kept confidential and does not impact admission decisions for your program.

Thank you for your support of our student.

Accessibility Centre, Lambton College
Fax: 866-622-9589
Tel: 519-479-2333
Email: ac@lambtoncollege.ca
1457 London Road, Sarnia, ON N7S 6K4

Section A: *To be completed by* ***Student***
Sections B - F: *To be completed by* ***Regulated Health Care Professional***

Please Note:

Students with Learning Disabilities
This form should not be used for information about a learning disability. To receive accommodations for a learning disability, please submit a copy of your most recent psycho-educational assessment.

SECTION A: Student Information & Consent - To be completed by Student

Name:____D.O.B.:_______ _____________________ _

Student Number: C0_________________________Phone:__________________________________ _

Please note:
While documentation confirming a disability is required to access accommodations and Ministry funding opportunities for qualifying student with disabilities, as per the Ontario Human Rights Code, disclosure of a specific diagnosis for health conditions is not a requirement to access academic accommodations and services from the AC. In these instances, detailed information on the functional limitation(s) of the disability is required for accommodation to be implemented.

Student consent to release of information pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I,__________________________, authorize my health care professional to complete the details of this form regarding my disability and to provide the following information to Accessibility Centre at Lambton College:

Check one:
- ☐ I give consent for a diagnosis to be provided
- ☐ I do not give consent for a diagnosis to be provided (consent to information on functional limitations only)

____ ________________________________
Student Signature Date

SECTION B: Confirmation of Disability - To be completed by Regulated Health Care Professional

Student Name: ____________________________________ **D.O.B.:**________________________

The following criteria must be met when determining a disability:

1. The student experiences functional limitation(s).
2. The functional limitation(s) impair(s) the student's academic functioning at the post-secondary level.

Please select the appropriate option:

☐ This student has a **permanent** disability with symptoms that are ☐continuous or ☐episodic

☐ This student has a **temporary** disability with symptoms that are ☐continuous or ☐episodic
Interim academic accommodations to be provided until date*: ____________________

☐ This student is being **monitored** to determine a diagnosis
Interim academic accommodations to be provided until date*: ____________________
**For Student:* Provide updated documentation prior to this date*

This student has been under your care for:
☐Less than 1 year ☐ 1 – 5 years ☐ More than 5 years ☐ First Visit

Diagnosed Permanent Disability (ies): *Disclosure of specific DSM diagnosis is voluntary - Verify on p.2.
If consent to provide a diagnosis has been provided, please check all that apply and comment if required:

- ☐ Acquired Brain Injury ____
- ☐ ADD/ ADHD ____
- ☐ Autism Spectrum Disorder ____
- ☐ Blind/ Low Vision ____
- ☐ Chronic Medical (e.g., Diabetes, Migraine, Epilepsy, etc.) ____________________________
- ☐ Deaf/ Hard of Hearing ____
- ☐ Specific Learning Disorder ____
- ☐ Intellectual Disability ____
- ☐ Mobility (CP, MS, Herniated Disc, Arthritis) ______________________________________
- ☐ Mental Health ____
- ☐ Other ____

Has the student been prescribed medication(s) that may impact academic functioning?
☐No ☐Yes If the student has been prescribed medication for this condition, what is the medication / dose?:
____
____

Are there side effects of the medication that are likely to affect academic functioning? Describe:
____
____

When is the medication likely to affect functioning negatively? (Click all that apply)
☐Morning ☐ Afternoon ☐ Evening ☐N/A

SECTION C: Functional Limitations of Disability - To be completed by Regulated Health Care Professional

Check/complete boxes to rate the impact of the impairment and possible medication effects (if any) on the areas of functioning listed below in relation to academics.

Skills/Abilities	No Impact	Mild Impact	Moderate Impact	Severe Impact	Not Assessed
COGNITION					
Communication (read, write, listen, speak, non-verbal)					
Judgement (anticipate impact of behaviour on self/others)					
Attention / Concentration					
Long-term Memory					
Short-term Memory					
Executive Functioning (behaviour & emotion, control; self-monitoring; shift focus; working memory; initiate, plan, organize & monitor tasks)					
Information Processing (verbal or written)					
Managing distractions (filter out stimuli)					
PHYSICAL					
Mobility					
Gross motor					
Fine motor					
Lifting					
Ability to sit for a sustained period of time					
Ability to stand for a sustained period of time					
Fatigue					
Chronic pain					
SENSORY					
Vision (with correction): Describe below					
Hearing (with correction): Describe below					
Speech: Describe below					
SOCIAL / EMOTIONAL					
Ability to read social cues					
Ability to respond to change effectively					
Effective emotional regulation in class					
Effective emotional regulation during evaluations					
Effectively manage demands of academic life					
Participate appropriately in class and group work					
Ability to perform class presentations					
OTHER: (Please describe)					

Please provide any additional information regarding functional limitations:

Do you consider the student capable of:

Sustaining a typical level of academic participation in their program? ☐Yes ☐No If No, please comment:

___

Participating in a work/field placement including completion of expected hours and duties of field work?
☐Yes ☐No If No, please comment:

___

Participating in a work/field placement with vulnerable populations? ☐Yes ☐No If No, please comment:

___

Maintaining a full-time course load? ☐Yes ☐No If No, please comment:

___

SECTION D: Specialized Equipment & Services - To be completed by Regulated Health Care Professional

Based on the functional limitations identified above, is there a need for specialized equipment and/or services? If "yes," please check items required and provide a rationale for the specialized equipment or service.

Specialized Services:

- ☐ Sign language interpretation
- ☐ Computerized note taking
- ☐ Documents in braille
- ☐ Other, please specify ___
- ☐ Large print
- ☐ Accessible textbooks, readings

Classroom Modifications:

- ☐ Ergonomic furniture
- ☐ Assigned seating

Assistive Technologies:

- ☐ Text to speech software
- ☐ Speech to text software
- ☐ Amplification system
- ☐ Other, please specify (e.g., requires use of memory aid)___
- ☐ Magnification software
- ☐ Video captioning

Rationale for Specialized Services/Equipment: ___

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___

___

SECTION E: Safety - To be completed by Regulated Health Care Professional

Does this student have a condition such that the college may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork, (e.g., seizure disorder, severe allergic reaction, mental health condition)?

☐No ☐Yes If “yes”, please describe condition(s) and provide further information:

____

____

____

SECTION F: Certification of Regulated Health Professional - PLEASE PRINT

Professionals are asked to complete only the areas that relate to their scope of practice (in Section B). Please complete as thoroughly as possible based on your knowledge of the student.

I,________________________________, am a legally qualified health care professional and this report contains my findings and considered opinion at this time, within my scope of practice.

Signature: ________________________________ License/Registration Number: ____________________

Date: ________________________________ Email: ________________________________

Phone: ________________________________ Fax: ________________________________

Medical Office Stamp:

Health Care Profession:

- ☐ Physician
- ☐ Psychiatrist
- ☐ Psychologist / Psychological Associate
- ☐ Physician: Specialization ________________
- ☐ Nurse Practitioner
- ☐ Audiologist
- ☐ Optometrist
- ☐ Chiropractor
- ☐ Other RHP:________________________

Send completed form to: Accessibility Services, Lambton College

Practitioner: By Fax: (866) 622 - 9589

Students: **By Digital Upload:** To upload documentation, request the upload link by emailing: ac@lambtoncollege.ca

By Dropping Documentation at B1-130

PLEASE DO NOT SEND DOCUMENTATION VIA MAIL