

Student Name: _____ Birthdate: _____

I am requesting disability support services through the Access Resource Centre (ARC) at the University of Northern British Columbia. The ARC requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability-related accommodations or services. Please respond to the following questions as soon as possible and return to me or send to ARC by fax (250-960-5775). I authorize ARC to contact you if clarification is needed.

Student Signature: _____ Date: _____

Name of Qualified Medical Assessor:		Registration No:
Specialty of Qualified Medical Assessor:		Medical Office Stamp
Signature:		
Date:		
Telephone No: ()	Facsimile No: ()	

The following area must be completed by the health care professional listed on this page. Please be as specific as possible. Thank you for your cooperation.

Optional: The student's diagnosis/diagnoses is/can be included below. While students are not required to provide formal diagnosis to receive services, having this information enables the ARC to provide the best possible service.

I have diagnosed the student with a DSM-5 psychiatric condition: Yes No N/A **Diagnosis(es):** _____

I have diagnosed the student with a medical condition: Yes No N/A **Diagnosis(es):** _____

Current status of condition(s) (e.g. active, progressing, controlled, in remission): _____

If temporary, how long is this condition(s) likely to persist (1 academic year, # of months): _____

Date of follow up appointment: _____

Disability Impact on Daily Functioning (as it relates to educational setting) (Check all that apply, please state if this is reported by the patient or by the assessor):

Physical Functional Impact	Unknown	No Impact	Mild Impact	Moderate Impact	Severe Impact	Patient Reports	Practitioner Reports
Standing							
Sitting							
Stair Climbing							
Handwriting							
Lifting/Carrying/Reaching							
Grasping/Gripping/Dexterity							
Energy levels/fatigue							
Other:							

Cognitive and/ or Behavioral Impacts	Unknown	No Impact	Mild Impact	Moderate Impact	Severe Impact	Patient Report	Practitioner Reports
Attention and Concentration							
Memory							
Information Processing speed							
Stress Management							
Thinking, reasoning, organizing							
Managing time							
Managing distractions							
Communication							
Regular and timely attendance							
Class/group participation							
Other:							

Please provide any additional information or recommendations. If you are unable to assess any of the impacts listed above, please note:

Medication

Is the person currently taking any prescription medications? Yes No

If yes, please indicate any side effects (alertness, concentration, nausea) that may affect participation in an educational environment:

If you think the student needs additional assessment, please indicate below:

Thank you for taking the time to complete this form. Feel free to include additional information, on your official letterhead, including copies of other applicable reports.