Appendix 12.2

Example Concussion/mTBI Accessibility Intake Package for Student Services/Special Needs Department*

Student Information Form
For Students with Acquired Brain Injury or Concussion

Last name: _____

First name: _____

Univeristy of Toronto Student Number: _____

University of Toronto Email: _____

Telephone:
Home: (_____) _____

Mobile: (_____) _____

May we leave a message? Please circle below
O Yes O No O Name and Number only
O Yes O No O Name and Number only

1. What is your present status at the University of Toronto? (Check all that apply)

O Undergraduate Student
Degree/Program: _____
Professional Faculty: _____
College (if an Arts & Science student): _____

O Graduate Student
Degree/Program: _____
Professional Faculty: _____

O Access Programs: Academic Bridging Program:_____ Transitional Year Program:_____

O Other (e.g., Non-Degree, Visiting) Specify:_____

O Income Student starting: _____ (e.g., Fall 2016, Winter 2017, etc.)

2. Have you registered with out service before? **O** Yes **O** No
If yes, who was your Disability Councellor? _____

3. Are you an International Student? **O** Yes **O** No
If yes, please provide your home country _____
_____

* Adapted from the Accessibility Services: Registration for New Students for the University of Toronto.

4. If you are a Canadian student, please provide your home province._____

5. Who referred you to Accessibility Services? _____

6. Do you require accommodation of any kind to participate in an intake interview with a Disability Counsellor?
O Yes **O** No

If yes, please indicate the type of accommodation:
_____

7. What assistance are you seeking from Accessibility Services?
_____
_____

8. Please indicate the category of disability/ies:

O Chronic Health Issue (e.g., epilepsy, irritable bowel disorders, migraines)
O Head Injury (e.g., concussion, traumatic brain injury)
O Learning Disability or Attention Deficit Hyperactivity Disorder (ADHD)
O Autism Spectrum Disorder (ASD)
O Mental Health Issue (e.g., anxiety, bi-polar, depression, disordered eating, OCD)
O Mobility / Functional Issue (e.g., use of a mobility device, repetitive strain injuries)
O Sensory Issue (e.g., legally blind, low vision, d/Deaf, hard of hearing)
O Temporary (please describe)_____

9. Describe your disability/ies in your own words.
_____
_____
_____

10. Is your disability (please check one):
O Permanent
O Progressive
O Temporary
O In the process of being assessed

11. Do you use an assistive mobility device? **O** Yes **O** No
If yes, please specify: **O** Power/manual wheelchair **O** Walker **O** Cane

12. Do you require any on-campus residence related accommodations? **O** Yes **O** No
If so, please provide more information about your needs:
_____
_____

13. If you're seeking accommodation for any medication-related side effects, please provide information about how your medication impacts you:
_____
_____

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14. Has anyone ever told you that you may have a learning disability? **O** Yes **O** No

15. Did you recently (within 2 years) complete high school or studies at another educational institution?
O Yes **O** No

If yes, please provide name of the educational institution: _____

If yes, please provide any disability-related accommodations you received at that educational institution (if any):

_____

_____

_____

16. How has your disability most recently impacted your academic functioning?

O Difficulty meeting deadlines and/or time management
O Concentration, focus, or attention issues
O Absences
O Difficulty completing required readings and/or understanding course material
O Difficulty with math
O Difficulty with presentations
O Difficulty with writing and/or academic writing and research
O Difficulty writing tests or exams

17. How has your disability most recently impacted your academic functioning? (continued)

O Not meeting academic potential
O Other (please explain)_____

18. What strategies do you use to manage the impact of your disability/ies on your academic functioning?

O Academic Coach
O Adaptive Technology/Equipment
O Counselling/Therapy
O Exercise/Meditation
O Massage therapy
O Medication
O Physiotherapy
O Tutoring
O Other (Please describe)_____

19. Do you receive or have you applied for provincial financial aid? (For example: Ontario Student Assistance Program – OSAP)? O Yes O No
If yes, are you eligible to receive provincial financial aid? O Yes O No

20. What are your reasons for attending the University of Toronto? What are your academic or career goals?

_____

_____

21. Do you have additional comments or questions? (If so, please add them in space below.)

_____

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Documentation for Students with an Acquired Brain Injury/Concussion

Accessibility/Disability Services provides support for students with documented disabilities, including those with Temporary Disabilities. If you have sustained an injury that limits your ability to attend to your academic responsibilities, you may be eligible to receive alternative accommodations and support from Accessibility Services. In order to determine your eligibility, contact our office as soon as possible and an appointment will be arranged. Accessibility Services requires documentation to verify your injury, which is important to bring to your first appointment.

Please include the documentation completed by a physician, neurologist, neurosurgeon, psychologist or neuropsychologist with the following information:

- Date of Injury
- Diagnosis and/or detailed description of injury
- Treatment plan
- Prescribed and over-the-counter medications with dosages
- Anticipated length of recovery

Please also note:

- If complications arise, or recovery takes longer than anticipated, students will be asked to provide additional documentation. If cognitive related challenges persist after one year post-injury, neuropsychological/cognitive assessment results will be needed to assist with accommodation planning. An adult cognitive assessment will be required for brain injuries sustained in childhood or adolescence with regards to residual cognitive challenges to help guide accommodations at the post-secondary level. Student may be eligible for a bursary/funding to assist with the costs of obtaining this type of assessment. Speak to your disability counsellor for further details.

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Medical Certificate for Acquired Brain Injury/Concussion-Related Issues

Dear Healthcare Practitioner,

This student is requesting disability-related supports and accommodations while studying at the University. The student is required to provide the University with documentation that is:

- provided by a licensed health-care practitioner, qualified in the appropriate specialty
- thorough enough to support the accommodations being considered or requested

Note: The provision of all reasonable accommodations and services is assessed based on the current impact of the disability on academic performance. A diagnosis is requested but not required for students to receive academic accommodations, however, a confirmation of disability and an understanding of the functional limitations is required.

CONFIDENTIALITY

The collection, use, and disclosure of this information resides under the guidelines of the Freedom of Information and Protection of Privacy Act (FIPPA). Under this legislation information may be shared on a need to know basis if it is required by another staff member in order to fulfill the responsibilities of their position. The documentation will be kept for a period of ten years.

To be completed by a regulated Healthcare Practitioner – Please Print Clearly

Patient's Name: _____

Patient's University Student Number: _____

Date of Birth: _____/_____/_____ (Year, Month, Day)

How long have you been treating this patient? _____

Last date of Clinical Assessment: _____

Statement of Disability:
Please indicate the appropriate statement for this student in the current academic setting:

- ☐ Permanent disability with on-going (chronic or episodic) symptoms (that will significantly impact the student over the course of their academic career). This functional limitation is expected to remain with you for the rest of your life.
- ☐ Temporary with anticipated duration from ____/____/____ to ____/____/____ (Year, Month, Day)
  *If unknown, please indicate reasonable duration for which s/he should be accommodated/supported at this time (please specify number of weeks/months or list the next date you will review the symptoms). _____

  _____

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Functional Impacts of Injury and Concurrent Conditions:

Date of Brain Injury/Concussion: _____

Description of Injury: _____

_____

The provision of a diagnosis in the documentation is requested but not required, however, disability documentation must still confirm the student's type of disability and the functional limitations. If the student consents, please provide a clear diagnostic statement; avoiding such terms as "suggests" or "is indicative of". If the diagnostic criteria are not present, this must be stated in the report.

Please note any FUNCTIONAL LIMITATION or concurrent conditions.

Please note all applicable:

Primary:

_____

Secondary:

_____

Additional / Other:

_____

Impacts:

_____

Medication(s):

Potential side effects of medication(s) on academic performance:

_____

Anticipated Date of Recovery:_____

Current treatment: (Check all that apply)

- ☐ Physiotherapy
- ☐ Chiropractic treatment
- ☐ Massage therapy
- ☐ Occupational therapy
- ☐ Speech language therapy
- ☐ Outpatient ABI treatment program
- ☐ Counselling
- ☐ Neuropsychological Assessment/Counselling
- ☐ Other_____

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Impacts on Academic Functioning:

Energy Level (please specify impact, e.g., fluctuating):

_____

_____

Impact on sleeping cycles:

_____

_____

Ability to manage full academic workload:

_____

_____

Recommendations for assignments/tests/exams:

_____

_____

Ability to manage practicum/placement activities (if applicable):

_____

_____

Impacts on Academic Work:

- ☐ Reduced Attention and Concentration
- ☐ Communication difficulties
- ☐ Slowed information processing speed (needing longer to complete written work/ complete tests)
- ☐ Memory Difficulties (difficulty learning and/or retaining new material)
- ☐ Reduction in organization skills and time management skills
- ☐ Difficulties with Social interactions
- ☐ Physical fatigue or pain
- ☐ Visual difficulties restricting ability to: view screens, read academic materials
- ☐ Other/comments:_____

Does this individual require any adaptive equipment (laptop, voice recorder, furniture or seating in class), software (Inspiration, Kurzweil) or other supports (massage, light box, counselling, FM system, CCTV, hearing aid etc.) to achieve academic success? **O** Yes **O** No

Please be specific about what is required.

_____

_____

_____

_____

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Healthcare Practitioner Information

Name of Healthcare Practitioner: (Please Print) _____

Signature: _____ Date:(DD/MM/YY): _____ /_____ /_____

Area of Specialization and License/Registration #:_____

- ☐ Physician
- ☐ Occupational Therapist
- ☐ Psychiatrist
- ☐ Sports Medicine Specialist
- ☐ Neurologist
- ☐ Neuropsychologist
- ☐ Psychologist
- ☐ Speech Pathologist
- ☐ Other

Facility/Clinic/Practice Name and Address: (Please use office stamp)

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Release of Information

TO BE COMPLETED BY STUDENT

I,_____, hereby authorize_____to provide
(Student) *(Name of Healthcare Practioner)*

the following information to Accessibility/Disability Services at the University and if required, to supply additional information relating to the provision of my academic accommodations and disability-related services. I understand that I am not required to disclose a diagnosis to receive academic accommodations and services. I also understand that documentation to provide a verification of a disability and the functional limitations is required. I authorize Accessibility/Disability Services to contact the Healthcare Practitioner to discuss the provision of accommodations.

I understand that any medical information provided from my healthcare provider resides under the guidelines under the Freedom of Information and Protection of Privacy Act (FIPPA). Under this legislation necessary information may be shared on a need to know basis if it is required by another U of T staff member in order to fulfill the responsibilities of their position.

Student's Signature:_____

University Student Number:_____

Date: _____

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