McGill | Student Accessibility and Achievement | Service étudiant d'accessibilité et d'aide à la réussite

DOCUMENTATION & STUDENT ACCESSIBILITY AND ACHIEVEMENT REFERRAL FORM

Student Accessibility and Achievement at McGill provisions academic accommodations to support students experiencing barriers, who have a documented disability, mental health disorder, chronic illness, or other impairment, whether temporary (i.e. concussion, broken bone), permanent (i.e. dyslexia, diabetes), or episodic (conditions that may have fluctuating symptoms or variations in impairment).

This form is a means of providing Student Accessibility and Achievement with information about this student's particular diagnosis(es) to determine reasonable academic accommodations.

Please note that a diagnosis alone does not automatically result in academic accommodations being required or provided. The provision of reasonable accommodations and services is determined based on the nature of the diagnosis and the current experience of barriers to academic achievement.

All information will be treated as strictly confidential.

STUDENT INFORMATION

Student name:	
Student number:	
Select all that apply:	**I am a:** ◯ Undergraduate ◯ Graduate ◯ Continuing Education ◯ Full time student ◯ Part-time student
I will be required to complete lab/fieldwork/practicum/placement as part of my program: ◯ Yes / ◯ No	

STUDENT CONSENT

I, _____ consent to the information provided in this document being disclosed to Student Accessibility and Achievement. I understand that my documentation will be treated as strictly confidential and will not be disclosed to others without my consent. I authorize Student Accessibility and Achievement to contact the undersigned professional to discuss information on this form as well as academic accommodations.

Student signature: _____ Date:_____

THE REMAINDER OF THIS FORM MUST BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL (Please see the PL-21 guide, section 3.6 for more information regarding the purview of each professional).

DIAGNOSTIC INFORMATION

1. The student has been my patient since: _____ **(DD/MM/YYYY)**
2. How did you arrive at this assessment? Please check all relevant items below:
   - o Structured interview(s) with the student
   - o Unstructured interview(s) with the student
   - o Interviews with other persons (parent, teacher, therapist)
   - o Behavioural observations
   - o Psycho-educational or Neuropsychological testing
   - o Other, please specify: _____
3. Please provide the specific diagnosis(es):

Diagnosis (**with the corresponding DSM-V code - if applicable**)	**Reported period of onset (MM/YYYY)**
1.	
2.	
3.	

Duration

◯ **Permanent Disability**	This student has a ***chronic impairment*** (a stable diagnosis expected to persist throughout the course of their studies at McGill University) with symptoms that are persistent, cyclic, or episodic.
◯ **Temporary Disability**	A ***temporary impairment*** from which the student may recover within 6-12 months. - Expected recovery by**: _____ (DD/MM/YR)** - If recovery is unknown, please indicate an approximate recovery timeframe by term **ending** ◯ Fall semester ◯ Winter semester ◯ Summer semester
◯ **Diagnostic Impression** (Please note that updated documentation may be required for continued academic accommodations).	This student is in the process of ***being monitored or assessed*:** ○ This student is being ***assessed*** to determine a diagnosis with results expected by: **_____(DD/MM/YR)** ○ Diagnosis unconfirmed – needs further assessment

IMPACT ON THE STUDENT'S ACADEMIC LIFE

1.1. Can you attest to this diagnosis resulting in significant and persistent barriers in the student's academic life? ◯ Yes ◯ No

1.2. Is the student currently experiencing side-effects of medication that may negatively impact academic achievement? ◯ Yes ◯ No

1.2.1. If so, please list all side effects that apply:

1.3. In your opinion, do you think that the student is able to take a full course load (180 hours / semester)? Please note that your response will not impact the student's ability to register as a full or part-time student. ◯ Yes ◯ No

1.3.1. If **no,** please indicate your reasoning for this recommendation:

PROFESSIONAL INFORMATION

Name:	
Professional title: (e.g. Psychologist, Physician, Psychiatrist, etc)	
License number:	
Address:	
Telephone number:	

Professional's Signature: _____ Date of consultation: _____