Student Information

Name:_____

Std ID No. :_____Student ID No._____Phone No: _____

Email address: _____

Health Care Practitioner Information

Name: _____

- ☐ Family Doctor
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Other Specialist Physician (specify):
- ☐ Other (specify):

_____

Following document is important in confirming the disability of the student and determining the specific need and support they require on campus. Hence the provided information should be filled after current & through assessment by registered healthcare professionals.

I am qualified to make a relevant diagnosis:

- ☐ Yes
- ☐ No

Signature with Stamp:_____ Date: _____
(dd/mm/yyyy)

Business Card or Letterhead also accepted

Part I: Student History

1. For how long have you been treating the student? _____

2. Will you continue to provide treatment to the student?

- ☐ Yes No
- ☐ Unknown
- ☐

3. Diagnostic procedure used to diagnose disability and identify functional and/or physical limitations (select all that apply):

- ☐ Behavioral Observations Date(s): _____
- ☐ Clinical Assessment Date(s): _____
- ☐ Diagnostic Imaging
  - ☐ MRI
  - ☐ CT
  - ☐ EEG
  - ☐ X-Ray
  - ☐ Other: _____
- ☐ Neuropsychological Assessment Date(s): _____
- ☐ Psychoeducational Assessment Date(s): _____
- ☐ Psychiatric Evaluation Date(s): _____
- ☐ Other: _____

Part II: Confirmation of Disability

1. Indicate the appropriate statement for this student in the current academic setting:

- ☐ By Birth/Permanent/Lifelong disability with ongoing (chronic or episodic) symptoms that will impact the student over the course of their academic career.
- ☐ Temporary disability resulted from sudden illness and/or accident with anticipated duration from_____to_____. In case, the exact duration is unknown, mention a reasonable duration for which student should be accommodated (i.e., number of weeks, months, end of term, etc.).
- ☐ Persistent/Prolonged but not permanent disability with ongoing, episodic symptoms that has lasted for more than 12 months and expected to last for at least the same duration.

2. Identify the student's primary type of disability and any associated condition/s if applicable

Nature of Disability	Primary Disability (check only 1)	Associated Disabilities (check whichever applies)
Acquired Brain Injury		
Attention Deficit (Hyperactivity) Disorder		
Autism Spectrum Disorder		
Chronic Illness		
Deaf, Deafened, Hard of Hearing		
Low Vision, Blind		
Mental Health*		
Other (If this student has a diagnosis of a learning disability, a psychoeducational assessment must be provided).		

Part III: Impact(s) on overall Academic Tenure

This part of the assessment form consists of all types of disabilities for the correct identification of functional and/or physical limitations of the student, there may be some questions which may not be relevant to the student's condition.

- ☐ Mild - Mild level of functional and/or physical limitation & requires minimal accommodation and/or support needed
- ☐ Moderate - Prominent functional and/or physical limitation & requires accommodation and/or support needed
- ☐ Serious - High degree functional and/or physical impairment that significantly interferes their academic performance & requires extensive accommodation and/or support needed
- ☐ Severe - Extreme functional and/or physical impairment that severely interferes their academic performance & requires extensive accommodation and/or support needed

Academic Task	N/A	Mild	Mod	Serious	Severe	Impact on Academic Performance
Listening						
Reading						
Taking Notes						
Completing Assignments/Reports						
Writing Test & Exams						
Delivering Presentations						
Meeting Deadlines						
Participating in Group Activities						
Functional/Physical Limitation						
Cognitive Skills & Abilities						
Attention & Concentration						
Organization, Planning & Time Management						
Information Processing						
Short-Term Memory						
Long-Term Memory						
Socio-Emotional						
Fatigue						
Managing a full course load						
Managing Stress						

Mood						
Social Interaction						
Attending Class						
Physical Limitation						
Gross Motor - Lifting/Reaching/Bending						
Fine Motor Skills & Manual Dexterity - Writing/Typing/Other						
Walking						
Stair Climbing						
Sitting for longer times						
Standing for longer times						
Others						
Sensory						
Vision - Right/Left/Bilateral						
Hearing - Right/Left/Bilateral						
Speech						

Does the student take any medication and/or regular treatment that may impact the student's academic performance? If yes, please elaborate

- ☐ Yes
- ☐ No

_____

_____

Additional information regarding the student's functional and/or physical limitations:

Part IV: Accommodation Recommendation(s) - Optional

Do you want to recommend specific accommodations and/or support to be provided to the said student, if yes, so please share your recommendation(s) and rationale(s) for each academic accommodation.