



Centre for Students with Disabilities (CSD)

CSD MEDICAL CERTIFICATE (2006)

Return form to

Manager, Centre for Students with Disabilities

ONTARIO COLLEGE OF ART & DESIGN (OCAD)
100 McCaul Street, Toronto, Canada M5T 1W1
T 416.977.6000 x288 F 647.438.9731

For CSD Office Use Only

- Psychiatric (PSY)
Medical (MED)
Deaf/Hard of Hearing (D/HOH)
Mobility (MOB)
Vision (VIS)

This student is requesting accommodations while studying at OCAD.
The student is required to provide the University with documentation that

- Is provided by a licensed professional, qualified in the appropriate specialty area.
Is thorough enough to support the accommodations/supports being considered or requested.

Confidentiality Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Patient's Name: _____

Patient's Date of Birth: _____

TO BE COMPLETED BY REGULATED HEALTH PRACTITIONER - PLEASE PRINT CLEARLY

How long have you been treating this patient? _____

Last date of Clinical Assessment _____

Diagnosis

(Avoid the use of such terms as "suggests" or "is indicative of." If the criteria for a diagnostic disability are not present, that must be stated in the report. Multiple diagnoses or co-existing conditions, which may influence academic progress, should be included; If Mental Health Disability - Note DSM diagnosis; Vision - identify Visual Acuity; Hearing - identify severity)

Pertinent Medical History (any relevant illnesses or injuries from birth to present):

Identify any relevant examinations, investigations, or consultations completed (i.e., MRI, x-ray, sleep study, etc.)

Date of Onset _____

Origin of Disability

MVA Date of Accident _____

Other: _____

Is the disability

Permanent (expected to remain with patient for their expected natural life)

Characterized by fluctuations in functioning

Progressive

Temporary Anticipated date of recovery: day ____ month ____ year ____

Medications

Brand or Generic name(s)

Dosage and Frequency

Classification

Adverse effect(s) student currently experiencing that impacts education

Impact on Activities of Daily Living

N/A

Please identify:

Impact on Education/Academic Functioning, please identify restrictions (i.e., patient should not sit or write for X period of time)

- The patient has been advised to reduce their course load
- Totally incapacitated - The patient has been/was unable to attend school from _____ until _____ (provide specific date)
- Other

Accommodations/Supports Recommended

Assistive Devices Recommended (i.e., CCTV, FM System, Hearing Aid, Mobility Aid, Brace, etc.)

- N/A

Date of next assessment

Treatment/Interventions Plan (i.e., physiotherapy, etc.)

Is there anything you would like to add that you believe is important to ensure that this patient receives the appropriate services at the university?

THANK YOU for taking the time to complete this. The information will facilitate the supports requested by your patient while at the university.

Name of Health Practitioner (please PRINT)		
Facility Name and address (USE Office stamp Here) NOTE: If you do not have an office stamp please sign and attach your letterhead – signatures on prescription pads will not be accepted		You are a: <input type="checkbox"/> Audiologist <input type="checkbox"/> Chiropractor <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Physician ○ Family ○ Psychiatrist <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist Other: _____
Health Practitioner Signature:		License No.
Date:	Telephone No.	Fax. No
Release of Information I, _____, hereby authorize this health practitioner to provide the following information to the Ontario College of Art and Design – Centre for Students with Disabilities, and, if required, to supply additional information, relating to the provision of my academic accommodations. I also authorize the Centre for Students with Disabilities to contact the physician to discuss the provision of accommodations. Patient’s Signature: _____ Date: _____		