DOCUMENTATION OF ACQUIRED BRAIN INJURY

STUDENT

☐ I understand that this form will be released to Academic Accommodations Services, University of Ottawa for the following purposes:

- to confirm the presence of an acquired brain injury;
- to identify if the condition is permanent or temporary;
- to evaluate functional limitations in the learning environment;
- to help Academic Accommodations Services determine appropriate accommodations and supports.

** The information you provide in the form can be used to assess the need for learning supports, academic accommodations, or access to a range of benefits including government funding.*

STUDENT NAME _____ STUDENT NUMBER _____

STUDENT SIGNATURE _____ DATE _____

WHO CAN COMPLETE THE FORM?

The documentation form is to be completed by the student's **treating Family Physician, Nurse Practitioner, Registered Psychologist, Neuropsychologist or Sports Medicine Physician**. The health professional has knowledge of the patient's history and is licensed to diagnose and treat acquired brain injuries. Students are not to fill out the medical form or functional limitations.

WHO SEES AND USES THIS INFORMATION?

Information provided will be used for the purposes described above and confidential in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA) and Personal Health Information Protection Act (PHIPA). If you have any further questions please contact us.

TO BE FILLED OUT BY TREATING FAMILY PHYSICIAN, REGISTERED PSYCHOLOGIST, NEUROPSYCHOLOGIST OR SPORTS MEDICINE PHYSICIAN

DIAGNOSTIC STATEMENT

☐ I confirm that I am in the process of assessing the student's condition to verify a diagnosis.

DIAGNOSTIC TESTING WILL BE COMPLETED ON: YEAR / MONTH / DAY

OR

☐ PLEASE STATE THE **CONFIRMED DIAGNOSIS**:

DURATION OF DISABILITY

☐ **PERMANENT:** The disability is expected to remain for the duration of postsecondary studies.

☐ **TEMPORARY:** The disability is expected to remain from YEAR / MONTH / DAY to YEAR / MONTH / DAY

☐ **UNKNOWN DURATION**

(Note: accommodations will be established for one semester until additional documentation is provided).

FLUCTUATING SYMPTOMS

☐ The student's disability has symptoms that can fluctuate.

TREATMENT PLAN Please update this document if the treatment plan changes.

1. **IF A DIAGNOSIS HAS BEEN CONFIRMED, WHEN WAS THE MOST RECENT HEAD INJURY?**
2. **HOW LONG HAVE YOU BEEN TREATING THE STUDENT FOR THE INJURY?**
3. **HOW MANY PAST HEAD INJURIES HAS THE STUDENT HAD?**
4. **WILL YOU BE MONITORING THE STUDENT ON A REGULAR BASIS?**
   ◯ YES, EVERY ◯ NO, THIS STUDENT WILL BE FOLLOWED BY
5. **IF THE STUDENT HAS BEEN PRESCRIBED MEDICATION FOR THIS CONDITION, CAN YOU SPECIFY CURRENT (IF ANY) SIDE EFFECTS THAT MAY IMPAIR THE STUDENT'S ACADEMIC PERFORMANCE?**
6. **DOES THE STUDENT HAVE LIMITED FUNCTIONING AT CERTAIN TIMES OF THE DAY? PLEASE CHECK ALL THAT APPLY:**
   ☐ MORNING ☐ AFTERNOON ☐ NIGHT PLEASE SPECIFY:
7. **DOES THE STUDENT RECEIVE OTHER TREATMENTS OR THERAPIES?**
8. **HAS THE STUDENT HAD NEUROPSYCHOLOGICAL TESTING?** ◯ YES ◯ NO
9. **PLEASE NOTE ANY ADDITIONAL DIAGNOSES WHICH COULD AFFECT THE RECOVERY PERIOD (IE: LEARNING DISORDER, ADHD, PSYCHIATRIC DISORDER, SLEEP DISORDER…) :**

Academic Accommodations Services
100 Marie-Curie Private, Room 408 Ottawa ON K1N 9N3
Phone : 613-562-5976 | Fax : 613-562-5159 | adapt@uOttawa.ca

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FUNCTIONAL LIMITATIONS THAT IMPACT THE UNIVERSITY ENVIRONMENT

NO IMPACT	MILD IMPACT	MODERATE IMPACT	SEVERE IMPACT
Unlikely to have an effect on ability to fulfill academic obligations.	Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms.	Student requires moderate supports or accommodations to succeed.	Significantly impaired in ability to fulfill academic obligations e.g. unable to complete some assignments, unable to write some tests/ examinations.

ATTENTION AND CONCENTRATION	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
MEMORY	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
INFORMATION PROCESSING	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
RATIONAL THINKING	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
TIME MANAGEMENT / ORGANIZATION	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
ABILITY TO CONTROL EMOTIONS	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
STRESS MANAGEMENT	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
ENERGY LEVEL	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
BALANCE / DIZZINESS	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
HEADACHES	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
NAUSEA	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
LIGHT SENSITIVITY	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
VISION PROBLEMS	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
LIGHT OR NOISE SENSITIVITY	☐ NO IMPACT ☐ MILD IMPACT ☐ MODERATE IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:

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Université d'Ottawa | University of Ottawa

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ACADEMIC WORKLOAD

UNDERGRADUATE: A minimum of 4 courses per semester is typically considered full-time.

GRADUATE: A minimum of 2 courses per semester is typically considered full-time.

1. BASED ON YOUR PROFESSIONAL OPINION, DO YOU THINK THE STUDENT IS ABLE TO MAINTAIN A COURSE LOAD OF:

5 OR MORE COURSES? ◯ YES ◯ NO | 4 COURSES (REDUCED FULL TIME)? ◯ YES ◯ NO | 2-3 COURSES? ◯ YES ◯ NO

2. BASED ON YOUR PROFESSIONAL OPINION, DO YOU CONSIDER THE STUDENT TO BE CAPABLE OF COMPLETING UNIVERSITY COURSES WHILE FOLLOWING THE TREATMENT PLAN AND WITH ACADEMIC SUPPORTS IN PLACE? ◯ YES ◯ NO

ADDITIONAL INFORMATION

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MAY ASSIST US IN SUPPORTING THE STUDENT.

VERIFICATION OF ASSESSING PROFESSIONAL

PLEASE SPECIFY TYPE OF PRACTITIONER:

☐ REGISTERED PSYCHOLOGIST ☐ NEUROPSYCHOLOGIST ☐ PSYCHIATRIST ☐ FAMILY PHYSICIAN ☐ OTHER

I am providing the above information for use by the University in assessing what academic accommodations, if any, should be offered to the student.
I understand I may be contacted by the University to verify this information, but will not be requested to provide further information without the consent of the student.

NAME	COLLEGE/ REGISTRATION #
ADDRESS	
PHONE NUMBER	FAX NUMBER

STAMP (IF AVAILABLE):

SIGNATURE

DATE

Note: The student is responsible for costs associated with completing this certificate.

The personal information on this form is collected under the authority of the University of Ottawa Act, S.O. 1965, C.137. At all times the personal information will be protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have any questions regarding this collection, please contact **the Access to Information and Privacy Office (AIPO)**.

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