



# Referral Form

## Regional Assessment and Resource Centre (RARC)

Queen's University - Mackintosh-Corry Hall, Room B100  
68 University Avenue – Kingston, ON K7L 3N6  
P: (613) 533-6311 | F: (613) 533-6564 | E: [rarc@queensu.ca](mailto:rarc@queensu.ca)



Date of Referral: \_\_\_\_\_ Referring Institution: \_\_\_\_\_

Accessibility Advisor: \_\_\_\_\_ Accessibility Advisor's Email: \_\_\_\_\_

Student Name: \_\_\_\_\_ Student #: \_\_\_\_\_

Student Email: \_\_\_\_\_ Student Phone Number: \_\_\_\_\_

|   |                                    |                                    |
|---|------------------------------------|------------------------------------|
| Program: _____  | <input type="checkbox"/> Full-Time | <input type="checkbox"/> Part-Time |
| How many semesters are left in student's current program? _____ |                                    |                                    |

### Please select the appropriate funding that applies for the student below (more than one may apply):

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Paying full fee out-of-pocket  | <input type="checkbox"/> Has private insurance coverage        | <input type="checkbox"/> Sliding scale fee |
| <input type="checkbox"/> OSAP BSWD/CSG-PDSE (Provincially and Federally Funded)               | <input type="checkbox"/> OSAP CSG-PDSE (Federally Funded Only) |  |
| <b>*If funded through BSWD and/or CSG-PDSE, when is the deadline for reimbursement?</b> _____ |  |  |

### Reason for Referral (Please select all boxes that apply):

|  |
|--|
| <input type="checkbox"/> Student previously diagnosed with neurodevelopmental disorder (Learning Disability, Attention Deficit/Hyperactivity Disorder, or Autism Spectrum Disorder) that causes academic impairment and requires updated documentation for the post-secondary environment to determine appropriate accommodations.<br><br>Please specify the neurodevelopmental disorder: _____      |
| <input type="checkbox"/> Student has historical and current undiagnosed academic challenges and requires an assessment to determine appropriate accommodations to access the post-secondary curriculum   |
| <input type="checkbox"/> Student has a medical condition (i.e., TBI, concussion) and/or complex medical history (i.e., epilepsy) and is experiencing what appears to be related academic impairment and an assessment is required to identify functional limitations arising from this condition to determine academic accommodations.<br><br>Please specify medical condition and/or history: _____ |
| <input type="checkbox"/> Other – Please be very specific as to why you suspect a neurodevelopmental disorder / condition and describe the academic impairment experienced by the student below:<br><br>_____   |

### Accommodation Status

|  |                                    |                                    |
|--|------------------------------------|------------------------------------|
| Is the student being accommodated for the current challenges or any other challenges?  | <input type="checkbox"/> Yes       | <input type="checkbox"/> No        |
| Are the accommodations temporary, pending the results of this assessment or permanent? | <input type="checkbox"/> Temporary | <input type="checkbox"/> Permanent |

Advisor/Student will submit required RARC documentation; **OR**  RARC to follow up with student for required documentation