Queen's Student Accessibility Services
Queen's University
Côté Sharp Wellness Centre, Mitchell Hall
69 Union Street | Kingston, ON | K7L 3N6
613-533-2506
https://www.queensu.ca/studentwellness/accessibility-services/

Queen's Verification of Mental Health Disability

PART A: Student Information
To be completed by Student

Last Name: _____ Preferred/Given Name: _____

Date of Birth: _____ Student Number: _____

Queen's Net ID: _____ Phone Number: _____

DISCLOSURE & CONFIDENTIALITY

- Sharing your medical diagnosis is not required to receive accommodations.
- To recommend appropriate accommodations QSAS uses information about functional impacts (i.e., how your medical diagnosis might impact you at university).
- QSAS will maintain confidentiality in accordance with the QSAS Statement of Confidentiality.
- All information on this form will be kept strictly confidential, even if consent to share medical diagnosis is not provided.

Do you consent to your medical diagnosis being identified on this form?

☐ I consent to having my medical diagnosis disclosed on this form.

☐ I **DO NOT** consent to having my medical diagnosis disclosed on this form.

Do you consent to having this form shared with Queen's Student Accessibility Services (QSAS)?

☐ I consent to having this form shared with QSAS.

☐ I **DO NOT** consent to having this form shared (QSAS).

Personal information is collected under the authority of the *Queen's University Royal Charter, 1841,* as amended, and will be used to provide disability-related services and accommodations for studies at university. Questions regarding the collection or use of this personal information should be directed to Manager, QSAS, 69 Union Street, Kingston, ON, K7L 3N6, (613) 533-2506, qsas.intake@queensu.ca.

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Student Name: _____ Student Number: _____

PART B: Health Care Professional Information

To be completed by Health Care Professional with detailed knowledge of student's disability and duration

Queen's Student Accessibility Services (QSAS) adheres to the Ontario Human Rights Code, the AODA, as well as Queen's Academic Accommodations for Students with Disabilities Policy to guide the provision of academic accommodations that remove barriers for students with disabilities while also upholding essential academic requirements.

Select the appropriate option below and then proceed to Part C.

☐ **I am the diagnosing Health Care Professional.**

Please indicate specialty:

☐ Nurse Practitioner ☐ Psychologist ☐ Other: (indicate on line below)

☐ Psychiatrist ☐ Family Physician _____

☐ **I am not the diagnosing Health Care Professional.**
I have reviewed third-party diagnosis with the student.

Diagnosing Health Care Professional specialty:

☐ Nurse Practitioner ☐ Psychologist ☐ Other: (indicate on line below)

☐ Psychiatrist ☐ Family Physician _____

Year of Diagnosis: _____

☐ **I am not the diagnosing Health Care Professional.**
I am working with this student to get a referral for an assessment.

Please select *Diagnosis Under Investigation* in PART C

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Student Name: _____ Student Number: _____

PART C: Disability Verification

To be completed by Health Care Professional with detailed knowledge of student's disability and duration

For QSAS to provide accommodations, the student must be experiencing functional impacts related to a diagnosed (or under investigation) mental health disability that is currently (or is expected to be) creating barriers to the student's access of post-secondary academics.

Select *one* of the options below, indicate diagnosis and duration, and then proceed to Part D.

☐ I confirm that I am in the process of monitoring the student's condition and/or disability diagnosis.

☐ **Diagnosis Under Investigation:** Disability under review/ awaiting an assessment or assessment results.

Anticipated Assessment Completion Date: _____

---------- CONTINUE TO PART D ----------

☐ I confirm that this student has a disability based on a diagnosed mental health condition.

Duration

☐ **Permanent:** Anticipated to impact student throughout academic career at Queen's.

☐ **Permanent (Episodic):** Anticipated to impact student through academic career with periods of good health.

☐ **Temporary:** Anticipated to impact student until _____/_____ (MM, YR)

Is student's condition expected to decline? ☐ YES ☐ NO

Diagnosis *(if student consented):*

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Student Name: _____ Student Number: _____

PART D: Functional Impacts

To be completed by Health Care Professional with detailed knowledge of student's disability and duration

QSAS relies on the detailed knowledge from a Health Care Professional of the student's disability and functional impacts to determine academic accommodations. Please note student preferences that are not related to the disability are outside the scope of this form.

Check all medical information and functional impacts the student experiences related to their disability

MEDICAL INFORMATION

Level of Severity	Mild	☐	Moderate	☐	Severe ☐
Date of Onset			____/____/____/		(DD, MM, YR)
Impacts worsen at different times of day *(if yes, when?)*	MORN.	☐	AFTER.	☐	EVEN. ☐
Could participation in academics be impacted by ongoing treatment?	YES	☐	NO	☐	

If yes, what impacts might this treatment have on the student's participation in their academics?

RESTRICTIONS

	N/A	Mild to Moderate	Serious to Severe	Comments
PHYSICAL				
Fatigue/Sleeping Difficulties				
Headache				
Nausea				
Sensitivity to Light				
THINKING				
Difficulty Concentrating				
Difficulty Organizing/Planning				
Difficulty Processing Information				
Difficulty Recalling Information				
SOCIO-EMOTIONAL				
Anxiety Level				
Depressed or Low Mood				
Difficulty Interacting with Others				
Difficulty Managing Distractions				
Difficulty Managing Stress				

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ACADEMIC IMPACTS

	N/A	Mild to Moderate	Serious to Severe	Comment
Attending Class				
Completing Exams				
Delivering Presentations				
Meeting Assignment Deadlines				
Participating in Group Activity				
Reading				
Taking Notes				
Writing Assignments				
Other				

COURSE LOAD

Would you recommend a Reduced Course Load for this student? YES ☐ NO ☐

ADDITIONAL INFORMATION

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Verification of Mental Health Disability

Student Name: _____ Student Number: _____

HEALTH CARE PROFESSIONAL INFORMATION	
Name (please print)	
Specialty	
Registration/License No.	
Facility Name and Address (Use Official Stamp if Available)	
Phone	
Email	
Signature	
Date	

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