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 Sensory Disability (Hearing/Vision)

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:

☐ Audiologist ☐ Neurologist ☐ Optometrist

☐ Ophthalmologist ☐ Other (indicate on line) _____

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

Diagnosing Health Care Professional specialty:

☐ Audiologist ☐ Neurologist ☐ Optometrist

☐ Ophthalmologist ☐ Other (indicate on line) _____

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) hearing or vision condition 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 (or under investigation) hearing or vision 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 - *General*

Impacts worsen at different times of day (*if yes, when?)* Morning ☐ Afternoon ☐ Evening ☐

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?

MEDICAL INFORMATION - *Hearing*

Severity with Corrective Technology

Left Ear ☐ Mild ☐ Moderate ☐ Severe

Right Ear ☐ Mild ☐ Moderate ☐ Severe

Severity w/out Corrective Technology

Left Ear ☐ Mild ☐ Moderate ☐ Severe

Right Ear ☐ Mild ☐ Moderate ☐ Severe

Date of Onset _____/_____/_____ (DD, MM, YR)

AIDS/SUPPORTS - *Hearing*

☐ Hearing Aid(s)
☐ FM System
☐ Real-Time Captioning
☐ Other: _____

☐ Cochlear Implant(s)
☐ ASL./English
☐ Video Captioning

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Student Name: _____ Student Number: _____

MEDICAL INFORMATION - *Vision*

Indicate severity of loss of the following:

Visual Field	☐ Mild	☐ Moderate	☐ Severe
Depth Perception	☐ Mild	☐ Moderate	☐ Severe
Colour Perception	☐ Mild	☐ Moderate	☐ Severe

Date of onset: _____/_____/_____ (DD, MM, YR)

Does student require alternatives to print format? ☐ YES ☐ NO

AIDS/SUPPORTS - *Vision*

- ☐ Screen-Reading Technology
- ☐ Guide Dog
- ☐ GPS for Wayfinding
- ☐ CCTV
- ☐ Text Enlargement (e.g., magnifiers)
- ☐ Dark or Other Special Glasses
- ☐ Other: _____

RESTRICTIONS

	N/A	Mild to Moderate	Serious to Severe	Comments
HEARING				
Hearing in classroom				
Speech				
Understanding speech and background noise				
Following/ responding to conversation				
Concentration/ sustained attention				
Ringing in ears				
Other				
VISION				
Reading print				
Reading on a screen				
Seeing lecture material in class				
Other				

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Student Name: _____ Student Number: _____

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

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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