



Medical Certificate - Accommodation

Return form to:

The Michener Institute, Susanne Seinader
222 St Patrick Street, Rm 442 Toronto, ON M5T 1V4
Telephone: (416) 596-3101x:1032 Fax: (416) 596-7214

This patient is requesting accommodations while studying at The Michener Institute. In order to consider the request the student is required to provide documentation which:

- 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

(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)

FIRST DAY SEEN _____

NATURE OF ILLNESS/INJURY (If psychiatric give DSM-IV Code) _____

ADDITIONAL CONDITIONS OR COMPLICATIONS _____

SYMPTOMS (including severity, frequency) _____

TREATMENT PLAN _____

REFERRAL TO _____

FINDINGS (Clinical Findings) _____

DATE OF LATEST VISIT _____ FREQUENCY OF VISITS _____

DATE OF HOSPITAL INPATIENT ADMISSION _____ DISCHARGE _____

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 (for example, patient should not sit, stand or write for X period of time, lifting restrictions by weight)

- 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.) <input type="checkbox"/> 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 Michener Institute?
<p>THANK YOU for taking the time to complete this.</p> <p>The information will facilitate the supports requested by your patient while at The Michener.</p>

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 <input type="checkbox"/> Other/Specialty: _____ _____
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Health Practitioner Signature:	License No.
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Date:	Telephone No.	Fax. No
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Release of Information

I, _____, hereby authorize this health practitioner to provide the following information to The Michener Institute – Accessibility & Accommodation Learning Advisor, and, if required, to supply additional information, relating to the provision of my academic accommodations. I also authorize the Accessibility & Accommodation Learning Advisor to contact the above health care provider to discuss the provision of accommodations.

Patient's Signature: _____ Date: _____