

**MEDICAL INFORMATION REQUEST FORM  
FOR MENTAL HEALTH CONDITIONS  
WITH OR WITHOUT COMORBIDITIES**



*ATTENTION HEALTH PRACTITIONER. This Medical Information Request Form will be used as one of the criteria to determine the student's eligibility to receive academic accommodations, support services, and financial supports at La Cité. All information received will be kept strictly confidential and does not impact admission decisions.*

**Note: Students with Learning Disabilities**

This form is **NOT** for information about a learning disability. Please submit a copy of the most recent psycho-educational assessment.

**SECTION A: To be completed by student**

Name: \_\_\_\_\_ D.O.B.(YYYY/ MM/ DD): \_\_\_\_\_ Student number: \_\_\_\_\_

Phone: \_\_\_\_\_ Address : \_\_\_\_\_

Campus: Ottawa Orléans Alfred Toronto Hawkesbury Online (Formation continue et en ligne)

**Student consent to release of information pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)**

Under the Ontario *Human Rights Code*, it is not a requirement to provide a **specific diagnosis** to access academic accommodations and services from the SAA at La Cité. However, students who want to disclose their diagnosis to their SAA counsellor may do so.

**Please note:** A diagnosis is however required to access some financial aid programs for students with disabilities. If you wish to access such funding, you may need to provide consent for the diagnosis information to be released.

Check one:

- I give consent to my Health Care Professional to complete this form **and provide a mental health diagnosis.**
- I give consent to my Health Care Professional to complete this form **without providing a mental health diagnosis.**
- I give consent to my Health Care Professional to complete this form **and provide my other diagnosis (es).**

\_\_\_\_\_  
Student signature

\_\_\_\_\_  
Date

**\*\*\*The student is responsible for costs associated with completing this medical form. \*\*\***

<b>SECTION B: To be completed by Regulated Health Care Professional</b>
---

**If the student has consented to disclose his mental health diagnosis(es), please indicate here :**

--

Was the diagnosis first established by you?  Yes  No

**If the student has consented to disclose other diagnosis (es), please indicate here:** (Autism Spectrum Disorder, Attention Deficit Disorder/Hyperactivity, Medical Condition, Mobility Impairment, Sensory Impairment)

--

Was the diagnosis first established by you?  Yes  No

The following **criteria must be met** when determining a disability.

1. The student experiences functional limitation(s) due to a health condition
2. The functional limitation(s) impairs the student's academic functioning at the post-secondary level

**Select the appropriate option:**

- I confirm that this student has a disability based on a diagnosed health condition according to the criteria outlined above.
- I am monitoring this student's condition to determine a diagnosis.

**Duration of the disability – Complete 1, 2 or 3.**

1. This student has a **permanent** disability with symptoms that are  continuous OR  episodic.

2. This student has a **temporary** disability with symptoms that are  continuous OR  episodic.

- Interim academic accommodations to be provided from \_\_\_\_\_ until \_\_\_\_\_.

3. This student is being **monitored** to determine a diagnosis

- Interim academic accommodations to be provided from \_\_\_\_\_ until \_\_\_\_\_\*.

*\*Updated documentation required after this date*

How long has this student been your patient? \_\_\_\_\_ Years OR  1<sup>st</sup> Visit/Walk-in

Do you monitor this student on a regular basis?  Yes  No

**Medications:**

Has the student been prescribed medication that may impact academic functioning?  Yes  No If yes, describe impact:

---

When is the medication likely to affect academic functioning negatively? (Check all that apply)

- Morning  Afternoon  Evening  N/A

**Impact of disability: check appropriate boxes below to indicate impact on academic functioning**

Skills/Abilities	No Impact	Mild Impact	Moderate Impact	Severe Impact	Unknown at this time
<b>COGNITION</b>					
Attention / Concentration					
Long-term Memory					
Short-term Memory					
Executive Functioning (planning, time management)					
Information Processing					
Anticipating impact of one's behavior on self/others					
Managing distractions (filter out stimuli)					
Communication (ability to effectively convey and receive information orally or in writing)					
Other:					
<b>PHYSICAL</b>					
Mobility					
Gross motor					
Fine motor					
Ability to sit for a sustained period of time					
Ability to stand for a sustained period of time					
Attendance / absence from class / punctuality					
Stamina (academic): ability to complete a full course load (25+ hrs of class per week)					
Other: (ex. fatigue, pain, tics, severe allergies, etc.)					
<b>SENSORY</b>					
Vision (with correction): Describe below					
Hearing (with correction): Describe below					
Speech: Describe below					
Other:					
<b>SOCIAL / EMOTIONAL</b>					
In-class and group work interactions (work cooperatively)					
Deliver oral class presentations					
Reading social cues					
Manage stress – during class					
Manage stress – during tests					
Adaptation to change					
Manage being away from home					
Be calm when interacting with others					
Approach professors when needed					
Accept feedback on performance without adverse reactions					
Other:					

Skills/Abilities					
	No Impact	Mild Impact	Moderate Impact	Severe Impact	Unknown at this time
<b>FIELDWORK-SPECIFIC SKILLS/ABILITIES</b>					
Work safely with vulnerable populations					
Stamina : ability to complete a 35 hr work week					
Ability to work on shifts (day, evening, night)					
Other:					

Please provide any additional information as needed:

**SAFETY:**

- 1) Does this student have a condition such that the college may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork (e.g. Convulsions, severe allergic reaction, risk for safety for self or others)? Yes No If yes, please comment:
- 

**Do you consider the student capable of:**

- 1) Tolerating the stress / pressure / physical demands associated with college studies? Yes No If no, please comment:
- 

- 2) Participating in a work/field placement? Yes No If no, please comment:
- 

- 3) Pursuing a full-time program course load (25 hours +)? Yes No

<b>SECTION C: Certification of Regulated Health Care Professional</b>
---

I have read the attached letter on the back of this page prior to completing this form \_\_\_\_\_ (initials)

I \_\_\_\_\_ am a legally qualified health care professional and this report contains my  
Full name  
 findings and considered opinion at this time, within my scope of practice.

Signature: \_\_\_\_\_ Licence/Registration Number: \_\_\_\_\_

Date: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

<p><b>Medical Office Stamp:</b></p>          	<p><b>Health Care Profession:</b></p> <p><input type="checkbox"/> Physician – Family</p> <p><input type="checkbox"/> Physician – Other: _____</p> <p><input type="checkbox"/> Psychologist / Psychological Associate</p> <p><input type="checkbox"/> Psychiatrist</p> <p><input type="checkbox"/> Other: _____</p>
---	--

<b>Please return this completed form to:</b>
--

<p>Collège La Cité          Service d'appui et d'adaptations          801, Aviation Parkway, C-1030          Ottawa, ON K1K 4R3          Fax: 613.742.2463          Tel: 613.742.2483 extension 2090  <a href="mailto:appui_adaptations@lacitec.on.ca">appui_adaptations@lacitec.on.ca</a></p>
--

Dear Health Care Professional,

You have been asked to complete this form by a student who wishes to register with the Service d'appui et d'adaptations (SAA) at collège La Cité. The SAA provides support services and academic accommodations for students with documented **permanent or temporary disabilities, with or without comorbidities**. Interim accommodations may be provided for students who are in the process of being assessed for a disability.

**We rely on your detailed knowledge of this student's disability, including a description of the current functional impairments that may impact his/her ability to participate in postsecondary education.** It will help determine appropriate academic accommodations to equalize the opportunity for the student to meet essential course or program requirements without creating an unfair advantage or undermining academic integrity. As you know, the post-secondary environment involves taking examinations, doing research, completing assignments, doing presentations, participating in fieldwork and assuming responsibility for one's higher education pursuits.

Under the Ontario *Human Rights Code*, it is not a requirement to provide a **specific mental health diagnosis** to access accommodations and support services in college. Disclosure of a diagnosis may be required for some government financial aid programs for students with disabilities. Students are asked to indicate if they provide consent to release this information on **page one** of this document.

*Thank you,*

Collège La Cité  
Service d'appui et d'adaptations  
801, Aviation Parkway, C-1030  
Ottawa, ON K1K 4R3  
Fax: 613.742.2463  
Tel: 613.742.2483 ext. 2090  
Email: [appui\\_adaptations@lacitec.on.ca](mailto:appui_adaptations@lacitec.on.ca)