THE Michener INSTITUTE of Education at UHN®

Medical Certificate - Accommodation

Return form to:
The Michener Institute, Health Services
222 St Patrick Streeet, Rm 442 Toronto, ON M5T 1V4
Telephone: (416) 596-3101x:3320 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 HOSITAL 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.)
❑ 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 Instititute?

THANK YOU for taking the time to complete this.
The information will facilitate the supports requested by your patient while at The Michener.

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:
- ❑ Audiologist
- ❑ Chiropractor
- ❑ Occupational Therapist
- ❑ Optometrist
- ❑ Ophthalmologist
- ❑ Physician
  - o Family
  - o Psychiatrist
- ❑ Physiotherapist
- ❑ Psychologist
- ❑ Speech-Language Pathologist
- ❑ Other/Specialty:

_____
_____

Health Practitioner Signature:	License No.

Date:	Telephone No.	Fax. No

Release of Information

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

Patient's Signature:_____Date:_____

09/11