**Student to complete this section**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Student ID:**  | u |  |  |  |  |  |  |  |

The University of Canberra uses as its guide the Commonwealth *Disability Discrimination Act* 1992 *(DDA),* the ACT *Discrimination Act* 1991,and theCommonwealth *Disability Standards for Education* 2005 (DSE) to ensure equal opportunity to higher education.

The InclusionUC Officesupports students with **disability and/or health condition(s)** with the implementation of supports, including reasonable adjustments and services, to enable students to study on the same basis as a student without disability and/or health condition(s).

Information supplied on this form and documentation supporting student registration and support is covered by the Commonwealth *Privacy Act 2014*.

|  |
| --- |
| I ………………..………… hereby give authority for …………………………….… |
| (Student Name) | (Practitioner Name) |
| to release the following medical information to the University of Canberra InclusionUC Office.  |
| I also give consent for the Inclusion Advisor to discuss my reasonable adjustment needs with my practitioner: | **[ ]  Yes** | **[ ]  No** |
| …………….……………………… | …/.../… |
| (Student Signature) | (Date) |

***The following information can only be accepted if completed by a Treating Health Practitioner.***

***Thank you for completing this form.***



InclusionUC

Student Life

**TREATING HEALTH PRACTITIONER’S REPORT - CONFIDENTIAL**

Dear Treating Health Practitioner,

Thank you for completing this form.

The University of Canberra uses as its guide the Commonwealth *Disability Discrimination Act* 1992 *(DDA),* the ACT *Discrimination Act* 1991,and theCommonwealth *Disability Standards for Education* 2005 (DSE) to ensure equal opportunity to higher education.

The InclusionUC Officesupports students with disability and/or health condition(s) with the implementation of supports, including reasonable adjustments and services, to enable students to study on the same basis as a student without disability and/or health condition(s).

To assist our office in assessing and providing appropriate supports and services we require a detailed medical opinion and a **current clinical diagnosis.**

Please provide detailed information on the impact of the diagnosis/es that may affect the students’ functionality. This will enable the University to meet the specific needs of the student appropriately. Please provide objective assessment results, where appropriate.

I have completed the Diagnosis Information and Impact Statements on pages 3 and 4 of this Health Practitioners Report:

|  |  |
| --- | --- |
| **Health Practitioners Name: …………………………………** | *Affix Stamp:* |
| **Profession: …………………………………** |  |
| **Provider Number: …………………………………** |  |
| **Health Service: …………………………………** |  |
| **Signature: …………………………………** | **Date:** | …/.../… |

**DIAGNOSISTIC INFORMATION FOR MEDICAL CONDITION/S OR DISABILITY**

|  |
| --- |
| **PRIMARY Medical Condition/s or Disability** |
| **The clinical diagnosis/es based on my examination is:****…** | **Onset** (if known)…/.../… | Examination date…/.../… |
| **Overall Impact** | [ ]  Slight  | [ ]  Moderate  | [ ]  Significant  | [ ]  Extreme |
| **Nature of condition** | [ ]  Stable  | [ ]  Fluctuating  | [ ]  Degenerative  | [ ]  N/A |
| **Duration**  | [ ]  Short Term  (<12 months) | [ ]  Medium Term  (12-24 months) | [ ]  Long Term  (Lifelong) |
| **Documentation Validity** | [ ]  6 Mths  | [ ]  1 Year  | [ ]  2 Years  | [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Diagnostic Tool Used**(if applicable)  | [ ]  DSM V  | [ ]  DASS  | [ ]  K-10 Valuation documentation to be attached if applicable. | [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **General Comment and/or Information:**(e.g. medication and management, referrals to other medical professionals, current or recommended treatment)**…** |
| **Secondary Medical Condition/s or Disability** |
| **The clinical diagnosis/es based on my examination is:****…** | **Onset** (if known)…/.../… | Examination date…/.../… |
| **Overall Impact** | [ ]  Slight  | [ ]  Moderate  | [ ]  Significant  | [ ]  Extreme |
| **Nature of condition** | [ ]  Stable  | [ ]  Fluctuating  | [ ]  Degenerative  | [ ]  N/A |
| **Duration**  | [ ]  Short Term  (<12 months) | [ ]  Medium Term  (12-24 months) | [ ]  Long Term  (Lifelong) |
| **Documentation Validity** | [ ]  6 Mths  | [ ]  1 Year  | [ ]  2 Years  | [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Diagnostic Tool Used**(if applicable) | [ ]  DSM V  | [ ]  DASS  | [ ]  K-10 Valuation documentation to be attached if applicable. | [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **General Comment and/or Information:**(e.g. Medication and management, referrals to other medical professionals, current or recommended treatment)**…** |

**To be completed by the Treating Medical Practitioner**

**IMPACT OF CONDITION OR DISABILITY ON FUNCTION**

***For each category, please provide details so we can facilitate appropriate adjustments or tick N/A.***

**My professional opinion is the nature and level of impact on:**

|  |
| --- |
| **Mobility are:** [ ]  N/A |
| **…** |
| **Reading are:** [ ]  N/A |
| **…** |
| **Writing are:** [ ]  N/A |
| **…** |
| **Concentration are:** [ ]  N/A |
| **…** |
| **Memory are:** [ ]  N/A |
| **…** |
| **Participation are**(e.g. attendance/active participation in tutorials)**:** [ ]  N/A |
| **…** |
| **Examinations are:** [ ]  N/A |
| **…** |
| **Clinical/work placements and/or field trips are:** [ ]  N/A |
| **…** |