**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 |
| **…** |