THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Treating Health Practitioner's Report

This form can be completed by a medical practitioner or board registered health practitioner.

The Disability Support Office assists students with a disability or medical condition. The following information will be used by the Disability Support Office to confirm the existence of a disability and/or health condition and to assist the University support your patient in their studies.

1. PERMISSION FOR RELEASE OF INFORMATION section to be completed by student

I _____ hereby consent that _____ can give detailed information on this form relating to my specific disability and/or medical condition that may be relevant to my ability to study.

Student's signature _____

Date ☐☐ / ☐☐ / ☐☐☐☐

2. DISABILITY MEDICAL INFORMATION section to be completed by medical/health practitioner

Condition	Mild	Moderate	Severe	Stabilised	Un-stabilised
Vision Impairment	☐	☐	☐	☐	☐
Acquired Brain Injury	☐	☐	☐	☐	☐
Dyslexia	☐	☐	☐	☐	☐
Dysgraphia	☐	☐	☐	☐	☐
Physical Injury	☐	☐	☐	☐	☐
Hearing Impairment	☐	☐	☐	☐	☐
Mobility	☐	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
ADHD	☐ Yes	☐ No			
Autism Spectrum Disorder	☐ Yes	☐ No			

3. MENTAL HEALTH CRISIS REFERRAL

Name of agency in case of emergency _____ Telephone _____

Further comments

_____

_____

_____

_____

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4. DISABILITY DURATION

Expected duration of disability ☐ Temporary (6-12 weeks) ☐ Ongoing (1-3 years) ☐ Permanent

The estimated time this person's disability will require adjustments

☐ Short-term ☐ Six weeks ☐ Six months ☐ One year ☐ Two years ☐ Three years

from _____ to _____

5. ACCESSIBILITY

Accessible room required ☐ Yes ☐ No

6. STUDENT'S DISABILITY OR CONDITION

Please give detailed comments regarding the impact of this student's disability or condition.

Impact on reading and/or writing

Impact on memory or concentration

Impact on preparation of essay and assignments

Effects of treatment which are likely to impact a student's ability to study

Other

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7. PRACTICUM/INTERNSHIP

Are there any major impacts on practicum/internship attendance that require specific adjustments?

☐ Yes ☐ No

If Yes, please give details

8. SPECIFIC RECOMMENDATIONS

Adjustments	Yes/No or specific details where applicable
Continuous Assessments The impact of the student's disability or condition requires an extension of time to submit a continuous assessment.	☐ Moderately ☐ Severely ☐ Very severely ☐ No
Examinations mid semester/end of semester A fixed additional time in the examination/s may be allocated to a student. The maximum additional time will be 15 minutes per hour. This time is inclusive of reading, writing and resting.	I confirm that the student will require additional time: ☐ Yes ☐ No Further comment
Small group setting	☐ Yes ☐ No
Computer (note Spell check to be supported by appropriate evidence, such as a SPELD report/test)	☐ Yes ☐ Spell check ☐ Enabled ☐ Disabled ☐ No
Scribe	☐ Yes ☐ No
Reader/translator/signer	☐ Yes ☐ No

8. FURTHER COMMENTS/ADVICE

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9. DOCUMENTATION VALIDITY

Documentation submitted is valid for:

☐ Six months ☐ One year ☐ Two years ☐ Three years ☐ Permanent

☐ Short-term If yes, specify the date: from _____ to _____

10. QUALIFIED HEALTH PRACTITIONER'S PROFESSIONAL DETAILS

Title | Surname name | First name | Profession

Number and street

Town/Suburb | State | Postcode

Telephone | Email

Practitioner's signature | Date ☐☐/☐☐/☐☐☐☐

Practitioner's stamp

Please return original completed form, together with any other relevant information to:
Disability Support Office, Academic Enabling & Support Centre, 28 Mouat Street, Fremantle

OFFICE USE ONLY

University stamp

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