



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acquired Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysgraphia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Autism Spectrum Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

3. MENTAL HEALTH CRISIS REFERRAL

Name of agency in case of emergency

Telephone

Further comments

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

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

8. FURTHER COMMENTS/ADVICE

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 (NDS5),
140 Broadway, Chippendale, NSW 2007

OFFICE USE ONLY

University stamp