Supplementary Form: Residence Special Accommodation Request: Documentation of Mental Health/Psychiatric Disabilities

Residence is a high-density living environment, and it means sharing physical space and other amenities. It requires skills to navigate living amongst a large number of peers and skills to maintain self-care, safety, and personal health. Living in a group setting has its benefit and challenges. It provides an opportunity to build relationships, learn life skills and develop personally. However, while there are community living standards, students must comprehend the implications of living around others – such as louder voices, people moving through the halls, people with different lifestyles or building sounds.

It may be difficult to control all aspects of the environment to the extent required to support some students' needs. Students must be self-sufficient while in residence and be able to keep themselves safe. This includes using existing services on campus for personal support to handle and manage your own personal needs.

The information provided on this form will only be viewed by the Department of Housing and Residence Life to assist with room placement and support. The information provided will be kept in a confidential record in accordance with the **Freedom of Information and Protection of Privacy Act.**

Please note, the student is not required to provide the DSM diagnosis to receive accommodation and support.

Student's Name:

Date (YYYY-MM-DD):

PART A: Student's Informed Consent (To be completed by the student)

I authorize Dr. to release this form and provide other information relevant for provision of room placement and support in the Department of Housing & Residence Life at Carleton University.

Student Signature: **Date (YYYY-MM-DD):**

Student's Informed Release is done in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

PART B: To be completed by a regulated health care professional

This form is to be completed by the treating psychiatrist, family physician, or nurse practitioner who has seen the student for more than one appointment.

Evaluation Requirements

A. To be completed by an appropriate **regulated mental health professional who has knowledge of the patient's history and is licensed to diagnose and treat mental health disorders**.
B. At the discretion of the Housing & Residence Life Department, documentation from **other regulated mental health professionals** may be accepted for the purpose of establishing **temporary/interim** disability services and accommodations.
C. All sections of the form must be completed fully and objectively to ensure **accurate assessment of the student's disability-related needs**, which may have significant implications on student's room placement or support received in residence.
D. Careful consideration should be given to the **statement of disability and relevant functional limitations**. Please note, the student is not required to provide the DSM diagnosis to receive accommodation and support. However, if diagnosis is not provided, functional limitations must be fully described and additional information may be requested in order to determine appropriate accommodation and support. **If you are unable to provide such information, the student may be referred for an internal assessment of functional limitations**.

Statement of Disability

Diagnostic Statement (see requirement D above): State your DSM diagnosis for this this student (to be provided only with student's consent):

Date of diagnosis (YYYY-MM-DD):

Please check one of the following three statements:

☐ **Temporary disability** with anticipated duration from

(YYYY-MM-DD) to (YYYY-MM-DD)

☐ **Chronic disability** that is expected to have an impact on the duration of the student's post-secondary studies

☐ **Permanent disability** that is expected to be remain with the student throughout their natural life

Assessment of Functional Impairments

Based on your professional opinion, please **describe and indicate the degree of impact** of each of the following areas of functional impairment as they relate to living in a community setting (on-campus residence).

	No Impact	Mild Impact	Moderate Impact	Severe Impact	Unknown
Cognitive processing of information	☐	☐	☐	☐	☐
Rational thinking and reasoning	☐	☐	☐	☐	☐
Social interactions	☐	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐	☐
Timely completion of tasks	☐	☐	☐	☐	☐
Personal Hygiene	☐	☐	☐	☐	☐
Activities of daily living (living independently)	☐	☐	☐	☐	☐
Self-regulation in daily activities	☐	☐	☐	☐	☐
Emotional Regulation	☐	☐	☐	☐	☐
Stress management	☐	☐	☐	☐	☐
Thoughts of Suicide:					
Non-suicidal self-injury	☐	☐	☐	☐	☐
Suicidal Ideation	☐	☐	☐	☐	☐
Suicide Attempts	☐	☐	☐	☐	☐

Limited functioning at certain times of day *(please specify)***:**	☐	☐	☐	☐	☐

Other *(please specify)*:

Living in a Residence Community

Based on your professional opinion, please questions below as they relate to living in a community setting (on-campus residence).

	Yes	No	N/A
Confirm living independently in a residence community is appropriate for the students needs?	☐	☐	☐
Confirm if the student has had any attempted overdoses in the last 6 months?	☐	☐	☐
If they are on medication, are they well enough to have possession of their own medication?	☐	☐	☐
Confirm that the student can live with a roommate?	☐	☐	☐
Confirm that the student can live with suitemates/pod mates?	☐	☐	☐
Can the student live in a community with 50-70 other students?	☐	☐	☐
Has the student seriously considered attempting suicide or developed a plan to do so within the last 12 months?	☐	☐	☐
Has this student attempted to die by suicide within the last 12 months?	☐	☐	☐
Has this student been hospitalized for mental health concern within the last 12 months?	☐	☐	☐

What additional support has been arranged for living in residence?

What is the student's plan of action plan for maintaining their wellness and safety while living in residence?

Would there be an impact on the student if they had to live off campus? If so, please indicate what the impact is and the degree of impact (No Impact, Mild Impact, Moderate Impact or Severe Impact).

Additional Information

How long have you been treating the student?

With the student's permission, please note any relevant multiple diagnoses or concurrent conditions that may impact their room placement.

Please provide any additional and relevant information that may assist us in supporting the student.

Certificate of Attending Registered/Certified Health Professional

I hereby certify that I provided health care services to, ,
a student at Carleton University. I am providing the above information for use by the University in assessing what academic accommodations, if any, should be offered to the student. I understand I may be contacted by the Department of Housing & Residence Life to verify this information, but will not be requested to provide further information without the consent of the student.

☐ **Psychiatrist** ☐ **Family Physician** ☐ **Nurse Practitioner**

Name:

Registration Number:

Address:

Telephone: **Fax:**

Email:

Signature:

Date (YYYY-MM-DD):

Stamp or business card here:

The personal information requested on this form is collected in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA), R.S.O. 1990, c.F.31 and the Personal Health Information Protection Act (PHIPA), 2004 SO 2004,c.3 as amended. The information provided will not be used for any purposes other than those stated upon this form unless the applicant provides express written consent. Should you have any questions concerning your personal information please contact the Privacy Office at phone: (613) 520-2600 ext. 2047, e-mail University.Privacy.Office@carleton.ca or mail: 607 Robertson Hall Carleton University 1125 Colonel By Drive, Ottawa Ontario K1S 5B6. Carleton University is fully compliant with FIPPA and PHIPA and endeavors at all times to treat your personal information in accordance with the law.

PART C: Consent to be Contacted (To be completed by the student)

I acknowledge that resources are allocated based on overall occupancy and availability. There are no guarantees in room type.

_____ **(Initial Here)**

I acknowledge that my Next of Kin will be notified in case of risk and/or emergency.

_____ **(Initial Here)**

I authorize the Department of Housing and Residence Life Services at Carleton University to contact me for additional information to assist in room placement and support.

Student Name: **CUID:**

Student Signature: **Date (YYYY-MM-DD):**