

**MEDICAL INFORMATION REQUEST**

|  |  |
| --- | --- |
| Patient/Student’s name: |  |
| Address (home): |  |
|  |  |
| Date of birth: |  |

**PURPOSE OF REQUEST:** This form should be completed in support of the patient/student’s disability-related needs in relation to their programme of study. The university makes reasonable adjustments for learning and teaching, which may include extended deadlines; exam adjustments; accommodation requirements; and level access.

**PATIENT/STUDENT CONSENT:**

I give consent for this form to be completed in support of my disability-related needs and academic studies.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SIGNATURE:** |  |  | **DATE:** |  |  |
| **PRINT NAME:** |  |  |  |  |  |

**MEDICAL PROFESSIONAL DETAILS**

|  |  |  |
| --- | --- | --- |
| Name: |  | |
| Job title: |  | |
| Certificate or registration number: |  | |
| Type of practice/organisation: |  | |
| Name of practice/organisation: |  | |
| Contact number: |  | |
| Address/Organisation Stamp:  **Note:** The Equality Act (2010) defines disability as:  “a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on the ability to do normal daily activities”  <https://www.gov.uk/definition-of-disability-under-equality-act-2010> | | |
| Does the patient/student have a physical, sensory or mental impairment which has a substantial and long term adverse effect on their ability to carry out normal day-today activities (including education)? | YES / NO |  |
|  |  | |
| Diagnosis/working diagnosis (including relevant dates): |  | |
|  |  | |
| Treatment/medication: |  | |
|  |  |  |
| Please describe the potential impact and/or symptoms of the patient/student’s disability in an education environment, including lectures, exams, getting to university and navigating the campus | | |  | |
| Please describe the potential impact of the patient/student’s disability in relation to their studies (coursework; exams; access needs):  Where applicable, will the patient/student require:   |  |  | | --- | --- | | Ensuite Facilities: | Disability-related (Yes) Preference (Yes) No or N/A  Reason (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Fridge (for medication only): | Yes No | | Accessible room: | Yes No | | Other (disability related-requirements, please provide full details): |  | | | |  |
| **MEDICAL PROFESSIONAL DECLARATION** |  | |
| Sign and date below to confirm that to the best of your knowledge the information provided is true and complete  SIGN / DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­ |  |  |
|
|