

**MEDICAL INFORMATION REQUEST**

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| --- | --- |
| 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**

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| --- | --- |
| 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/AReason (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Fridge (for medication only): | [ ] Yes [ ] No |
| Accessible room: | [ ] Yes [ ] No |
| Other (disability related-requirements, please provide full details): |  |

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| **MEDICAL PROFESSIONAL DECLARATION** |  |
| Sign and date below to confirm that to the best of your knowledge the information provided is true and completeSIGN / DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­ |  |  |
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