Student Number: ______________________________

Student Name: ______________________________

Health Practitioner Report:

BondAbility provides support and services for students at Bond University with a disability or medical condition. The following information will be used by the Accessibility and Inclusion Advisor (AIA) to assist in providing the most appropriate academic support for your patient/ client. You are welcome to contact the AIA by emailing accessibility@bond.edu.au if you require further information.

Consent to Release/Exchange Information

I, ______________________________ (**student's name**) hereby give authority for Accessibility and Inclusion Advisor to contact my health professional (details below), regarding documentation and the nature of my disability/medical condition, and also for my health professional to contact the Accessibility and Inclusion Advisor regarding documentation and the nature of my disability/medical condition as it pertains to my academic performance.

Student Signature: _________________________ **Date**: _______

Health Professional's name: ____ Phone: ______________________

Email: ____ Fax: ________________________

Diagnosis and prognosis. *Note: some conditions will require additional diagnostic information: Learning disabilities require psychometric report, Hearing impairments require Audiologist report, ADHD and neurodiverse conditions require diagnosis by a psychologist.*

Diagnosis:

Are these disabilities or medical conditions:

☐ Temporary. Expected to resolve ___ /___ /___

☐ Long-term. Expected to resolve ___ /___ /___

☐ Permanent

Is this condition fluctuating or episodic? ☐ Yes ☐ No

Functional impacts of disability or medical condition on study at Bond University. *Please consider how the disability or medical conditions impact study: for example, fatigue, concentration, standing and sitting tolerances.*

Adjustments currently required at home/education considering functional impairment: *For example, do they limit their driving time, do they limit their sitting time, regular breaks to aid concentration.*

Effect of medication. *Please consider how medication impacts concentration and memory, mobility and stamina, visual or other systems.*

Health practitioner's details

Provider name ______________________

Profession: ______________________

Provide number: ______________________

Signature: ______________________

Date: ______________________

Provider stamp