**MEDICAL INFORMATION REQUEST**

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

**MEDICAL INFORMATION REQUESTED BY:**

**JOB TITLE:** Disability Adviser, University of Roehampton

**CONTACT DETAILS:** Email: [disabilities@roehampton.ac.uk](mailto:disabilities@roehampton.ac.uk)

Tel: 0208 392 3636

Disability Services

University of Roehampton

London SW15 5PU

**PURPOSE OF REQUEST:** I require confirmation of the above named patient’s disability/medical condition. It would help if you could fill in information on the next page giving as much details as possible:

This information is necessary for us to provide the student with relevant study support, university parking permits, on-campus accommodation etc, and could enable the student to secure Disabled Student’s Allowance or other forms of additional funding.

If we have specifically requested medical evidence in support of a student's application for either on-campus accommodation or a parking permit, then the information provided must clearly state in what ways having neither of these would seriously impact upon the student's ability to attend the university and participate fully in his/her programme of study.

The letter can be handed direct to the patient or emailed or posted to the address above.

**PATIENT CONSENT:**

I give consent for my doctor to write to the person named above confirming any medical condition and/or disability which may have an impact on my ability to study.

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

**MEDICAL PROFESSIONAL DETAILS**

|  |  |  |
| --- | --- | --- |
| Full name: |  | |
| Job title: |  | |
| Certificate or registration number: |  | |
| Type of practice/organisation: |  | |
| Name of practice/organisation: |  | |
| Address: |  | |
|  |  | |
| Contact number: |  | |
|  |  | |
|  |  | |
| **ABOUT STUDENT'S DISABILTY** |  |  |
|  |  |  |
| Does the 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), **as defined by the Equality Act (2010) definition of disability**?   * *see note below for definition* | YES / NO | |
| **If yes, give details:** |  | |
| Name the condition and describe its impact upon the patient’s day to day life, including education; |  | |
|  |  |  |
| Let us know how long the patient has had the condition and what the prognosis is; |  | |
|  |  |  |
| Describe any treatment they are having for the condition and whether that treatment causes any side effects for this particular patient.) |  | |
|  |  |  |
| Diagnosis/working diagnosis (including any relevant dates) |  | |
|  |  |  |
| Please describe the potential impact of the patient’s disability in an education environment, including lectures, exams, getting to university and navigating the campus | | |
| If the patient is also applying for on campus accommodation, please indicate the effect of their disability on day to day housing requirements including for example side effects of medication, fatigue, anxiety, personal care, access issues or need for ensuite facilities: | | |
| **MEDICAL PROFESSIONAL DECLARATION** |  | |
| Sign and date below to confirm that to the best of your knowledge the information you've provided is true and complete |  |  |
|
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|  |  |  |
|  |  |  |
| **YOUR SIGNATURE** |
|  |  |  |
|  |
| **DATE:** |

**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>