

Section E: Visual Impairment (to be completed by an Ophthalmologist or Optometrist)

I certify this client to be visually impaired according to the following criteria. (Indicate appropriate description):

- A visual acuity of 6/21 (20/70), or less in the better eye after correction.
- A visual field of 20 degrees or less.
- Any progressive eye disease with a prognosis of becoming one of the above, in the next two years.
- Near point vision for print reading of _____.

Diagnosis:

Please Complete Section K on Pages 6 & 7

Section F: Neurological Disability (to be completed by a Neurologist, Psychiatrist or Physician)

Examples: cerebral palsy, epilepsy, multiple sclerosis, brain tumor, stroke, traumatic brain injury, etc.

Primary Diagnosis:

Medication and side effects: (if applicable)

Please Complete Section K on Pages 6 & 7

Section G: ADD / ADHD (to be completed by a qualified Psychiatrist, Psychologist or Physician)

I certify this client to be ADD / ADHD according to the following criteria. (Indicate appropriate description):

Diagnosis according to DSM-IV criteria and background history is: (Please provide details in Section J)

- ADHD Inattentive Type
- ADHD Impulsive -Hyperactive Type
- ADHD Combined Type

Please provide the following information: diagnosis according to the DSM IV Criteria, year of diagnosis, background history, diagnostic tools used, medication used and side effects. (Attach separate sheet if needed)

Please advise client to submit any other supporting documentation in reference to their learning needs along with copies of any previous Psycho-Educational Assessments if available.

Please Complete Section K on Pages 6 & 7

Section H: Psychiatric Disability (to be completed by a Clinical Psychologist, Psychiatrist or Physician)

Example: Mental Health Consumer
Primary Diagnosis: (according to DSM-IV criteria)
Year of Diagnosis:
Medication and side effects: (if applicable)
<i>Please Complete Section K on Pages 6 & 7</i>

Section I: Other Diagnosed Disabilities (to be completed by the appropriate medical assessor)

Example: Developmental Disability, Intellectual, Autism Spectrum Disorder, FAS, etc.
Primary Diagnosis:
I certify this applicant to have _____ based on the following:
<input type="checkbox"/> Psycho-Educational Assessment (Please include a copy)
<input type="checkbox"/> Medical Assessment
<input type="checkbox"/> Other - Please Specify:
<i>Please Complete Section K on Pages 6 & 7</i>

Section J: Other Chronic Illnesses/Syndromes (to be completed by the appropriate medical assessor)

Examples: fibromyalgia, crohn's, lupus, etc.
Primary Diagnosis:
Year of Diagnosis:
Medication and side effects: (if applicable)
<i>Please Complete Section K on Pages 6 & 7</i>

Section K: (continued)

Part C: Medical Assessor Information	
I certify that the information provided on this form is accurate and the student identified in this assessment experiences the disability-related educational barriers indicated.	
Name of certifying Medical Assessor: (Please Print) _____	
Mailing Address: _____	
City/Town: _____	Province: _____ Postal Code: _____
Telephone: _____	
Signature: (must be signed in ink)	Date: _____ <i>Day / Month / Year</i>

Please return this form to the student or forward all pages of this form to the address below. It would also be beneficial for the applicant to have a copy of the completed form for their records.

Nova Scotia Student Assistance
PO Box 2290, Halifax Central
Halifax, NS B3J 3C8

Telephone: 424-8420 Toll Free in Canada 1-800-565-8420