Confidential

Health Practitioner Report

Part A – Student to complete

This form is to be completed by your treating practitioner or specialist to support your request for alternative supports.

For conditions that require a diagnosis by a specialised practitioner, please provide this form to the relevant practitioner or provide Access and Inclusion with previous documentation confirming the diagnosis by that practitioner. This includes conditions such as ADHD, autism spectrum disorder and specific learning disabilities such as dyslexia, dysgraphia, and dyscalculia. Additional supporting documents may be required.

Please sign below to authorise Access & Inclusion to contact the referring practitioner and for the referring practitioner (or their service to act on their behalf) to clarify or provide additional information in relation to your condition and accommodations to Access & Inclusion.

Student Name: _____ Student Number: _____

Student Signature: _____ Date: _____

Part B – Practitioner/Specialist to complete

Please forward this completed form and any supporting documentation to access@murdoch.edu.au OR fax the documents to (08) 9360 6502 OR return them to the student in a sealed envelope.

The information that you provide will be used in conjunction with information from the student, assessment by Access and Inclusion, University processes and the *Disability Discrimination Act 1992* and *Disability Standards Education 2005* to implement study adjustments.

1. Student Name: _____ Date of birth:_____

2. Name and job title of practitioner or specialist (registered with Australian Health Practitioner Regulation Agency or appropriate medical practitioners' registration board or authority in respective countries) completing this form:

   _____

3. Medical practitioner **registration** number: _____

4. Diagnosis of student's disability/medical condition(s): *NB: for conditions that require a diagnosis by a specialised practitioner, please also provide documentation confirming the diagnosis by that practitioner. For example, autism spectrum disorder and specific learning disabilities e.g. dyslexia, dysgraphia, and dyscalculia.*

   _____

4a. If diagnosis is ADHD:
Psychologists/psychiatrists/paediatricians, please confirm by signing the below that you have met with the above-named student and diagnosed ADHD based on comprehensive observational and diagnostic assessments.

Name: _____ Sign: _____.

5. Is the condition permanent or temporary? (Provide date condition is expected to be resolved):

_____

6. Please indicate if the above condition is episodic/periodic/chronic and mild/moderate/severe:

_____

7. List the functional impacts of the condition as they apply to this student, e.g., inability to sit for long periods, fatigue, loss of concentration, medication effects etc. This information will be used by Access & Inclusion in determining relevant study adjustments.

Practitioner Signature: _____

Date:

Provider Stamp

Please contact Access & Inclusion Office on +61 8 9360 6084 if you have any queries.