## La Trobe University Logo

## La Trobe University,

## Victoria 3086 Australia

## AccessAbility Hub

## Student Health and Wellbeing

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## W [AccessAbility Hub](https://www.latrobe.edu.au/students/support/wellbeing/accessability-hub/contacts)

# Health Practitioner Statement

## Instructions

This statement can only be completed and signed by a treating health practitioner who can verify that a student identifies as Autistic, ADHD, Dyslexic and/or another minority neurotype with Neurodiversity support needs, or lives with or has a mental health condition, ongoing medical condition or disability (this may include physical, neurological, intellectual, sensory, acquired brain injury, or specific learning difficulty).

The practitioner should be registered with the Australian Health Practitioner Regulation Agency (AHPRA) or equivalent professional association.

Information provided will be used by an AccessAbility Adviser, in consultation with the student, to recommend reasonable adjustments to support the student in their studies at La Trobe University.

All information is collected in accordance with [Privacy Laws and Principles](https://www.latrobe.edu.au/privacy/laws-principles). Refer to La Trobe’s [Privacy Collection Notice](https://www.latrobe.edu.au/privacy/student-information/privacy-collection-notice) for more details.

***Student Authority for the provision of information (to be completed by the student)***

*I hereby authorise my health practitioner to release relevant health information to the AccessAbility Hub, La Trobe University.* *I understand that my health practitioner may be contacted to discuss or verify any of the information contained in this form.*

*Student Name: Student ID Number:*

*Student signature: Date:*

**Please provide a diagnosis/description of the above student’s circumstance:**

*(Please use space provided below/attach additional documents if required)*

**Please indicate whether the condition or disability is:**

Short Term: until following date:

Temporary: until mid-yearfor the academic year

Ongoing: for the duration of studies

and is either:  Fluctuating  Constant

**Please indicate the areas that are impacted by the condition or disability:**

**Reading:** **Writing:**  **Communication:** **Groupwork:**  **Memory:** **Mobility:**  **Attention/concentration:** **Planning/Organising:** **Participation (classes/practical/labs):**  **Completion of essays/assignments within timeframes:**  **Timed tests and examinations:**

**Participation in clinical placements and field trips:**

**Additional comments / Other relevant details of impact on participation in education:**

*(Please use space provide below/attach additional documents if required)*

**Recommended strategies for minimising the impact of the student’s condition or disability in a timed test/examination.** (Recommendations for reasonable adjustments will be reviewed by AccessAbility Advisors to ensure they align with inherent requirements of the student’s course).

extra time

use of equipment such as a computer, assistive technology, ergonomic furniture, medical equipment etc.

separate venue

**Other recommended strategies:**

*(Please use space provide below/attach additional documents if required)*

**Health Practitioner Declaration**

By completing and signing this form I confirm that:

* I am the treating Health Practitioner for the above-named student.
* I am qualified to verify the circumstances for which the student is requesting reasonable adjustments.
* I agree that I can be contacted to provide additional information or authenticate this document.

**Important**: For students who identify as Autistic, ADHD, Dyslexic and/or another minority neurotype with Neurodiversity support needs, please provide relevant documentation that includes tests designed to assess and diagnose such conditions for an adult (aged 16 years or older) where available.

Name of Practitioner: Profession:

Phone number: Registration/Provider No:

Signature: Date: