UNIVERSITY OF LEADING THE WAY WESTMINSTER

Disability Learning Support
1st Floor Cavendish House,
101 New Cavendish Street,
London, W1W 6XH

E: DLS@westminster.ac.uk
T: +44 (0) 20 350 68800
W: http://www.westminster.ac.uk/disabilities

MEDICAL/DIAGNOSTIC INFORMATION REQUEST

PURPOSE OF REQUEST: this form is to enable the student to register with Disability Learning Supportso they can access support at the University of Westminster.

COMPLETED BY STUDENT

Name:

Date of birth:

STUDENT CONSENT: I give consent for my doctor/relevant professional to complete this from.

Signature:

Date:

COMPLETED BY MEDICAL PROFESSIONAL

Please document the current and previous use of Primary, Secondary and/or Specialist Services

Primary Services	Secondary Services	Other Specialist Services
☐ GP	☐ Consultant	☐ Other services (e.g. support from National Charities, such as The National Autistic Society) Please give details:
☐ Practice/Specialist Nurse	☐ Community setting e.g. Occupational Health, Community Psychiatric Nurse	
☐ Other (e.g. IAPT)	☐ Primary care setting e.g. Social Worker, Care Coordinator	
☐ Other:	☐ Hospital Admission	
	Other:	

COMPLETED BY MEDICAL PROFESSIONAL

Does the student have a physical, sensory or mental health condition which has a substantial and long term adverse effect on their ability to carry out normal day-today activities (including education)? To be considered long term, the effect of the disability must have lasted or be likely to last at least 12 months	☐ Yes (Please give details below) ☐ No
Diagnosis/working diagnosis (including any relevant dates)	
Please describe any current treatment/medication and any relevant side effects	
Please describe the (potential) impact of the student's disability in a higher education environment (e.g. attending lectures, exams, getting to university and navigating the campus)	[Please continue on a separate sheet if necessary]

COMPLETED BY MEDICAL PROFESSIONAL

Full name:

Job title:

Type of practice/organisation:

Name of practice/organisation:

Address:

Phone number:

Email:

Certificate or registration number (GMC, HPC, NMC):

Practice stamp:

MEDICAL PROFESSIONAL DECLARATION

I confirm that the information I have provided is true and complete to the best of my knowledge

Signature:

Date: