**Working Diagnosis Form**

In order to qualify for disability support you will need to provide the Disability Support and Inclusion Team with written evidence. Please ask your doctor or consultant to complete this form. When you receive the completed form back, please forward it on to our service at the email below.

**Please note that you will need to pay for any fee charged by your medical practitioner in order to complete this form. York St John University cannot meet this cost.**

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| --- | --- |
| **Student name:** | **Date of Birth:** |

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| --- |
| **This student has a condition which has lasted or is likely to last for a year or more****Yes □ No □**  |
| **Diagnosis / working diagnosis:** |

|  |
| --- |
| **Symptoms of condition/impairment *(Please tick all that apply)*:** |
| **Pain** |  | **Fatigue** |  | **Reduced ability to process information** |  |
| **Anxiety** |  | **Reduced concentration** |  | **Communication difficulties** |  |
| **Low mood** |  | **Reduced memory** |  | **Sleep problems** |  |
| **Other symptoms/additional information:** |

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| **Impact on study *(Please tick all that apply)*:** |
| **Attendance** |  | **Group work** |  | **Moving around the campus** |  |
| **Meeting deadlines** |  | **Note taking** |  | **Placements** |  |
| **Organisation and planning** |  | **Reading and research** |  | **Exams** |  |
| **Other impact/additional information:** |

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| **Medical/Mental Health Professional Details** |
| **Name:** |  |
| **Job title:** |  |
| **Registration/Practicing Certificate Number:**(GMC, HPC, NMC) |  |
| **Organisation address:** |  |
| **Organisation stamp:** |  |

**Medical/Mental Health Professional Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please return completed form to** **learningsupport@yorksj.ac.uk** **.**