ACCESSIBILITY NEEDS IN RESIDENCE

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Please leave the questions blank that you do not feel comfortable answering.

### STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Student Number:</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Address:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Home Telephone:</th>
<th>Alternate Telephone: ( cell  pager  work)</th>
</tr>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>E-mail: (must be @utoronto.ca)</th>
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<table>
<thead>
<tr>
<th>Language:</th>
<th>English  French  Sign language (ASL/LSQ)</th>
</tr>
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<tr>
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</table>

Are you in receipt of funds from an insurance company for Attendant Services as a result of a settlement?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
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</table>

### TYPE OF DISABILITY (please check all that apply)

<table>
<thead>
<tr>
<th>Acquired Brain Injury</th>
<th>Collitis</th>
<th>Irritable Bowel Syndrome</th>
<th>Neurological (non-progressive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputation</td>
<td>Cerebral Palsy</td>
<td>Cystic Fibrosis</td>
<td>Neurological (progressive)</td>
</tr>
<tr>
<td>Arthritis/Rheumatic Conditions</td>
<td>Deaf</td>
<td>Deafened</td>
<td>Paraplegia</td>
</tr>
<tr>
<td>Low vision</td>
<td>Hard of Hearing</td>
<td>Heart Condition</td>
<td>Quadriplegia</td>
</tr>
<tr>
<td>Blind</td>
<td>Diabetes</td>
<td>Diplegia</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Bone Disorders</td>
<td>Multiple Sclerosis</td>
<td>Fibromyalgia</td>
<td>Spina Bifida</td>
</tr>
<tr>
<td>Brain Trauma</td>
<td>Muscular Dystrophy</td>
<td>Muscular Disorders</td>
<td>Stroke</td>
</tr>
<tr>
<td>Chronic Fatigue Syndrome</td>
<td></td>
<td></td>
<td>Other: ______________</td>
</tr>
<tr>
<td>Crohns Disease</td>
<td></td>
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</tbody>
</table>

### EMERGENCY CONTACT PERSON

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Telephone:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
CURRENT SOURCE OF SUPPORT SERVICE (check all that apply)

- Family/Friends
- Homemakers
- Private Attendant (Agency registered _________)
- Visiting Nurse
- Oral Intervener/Interpreter
- None

ASSISTIVE DEVICES USED (check all that apply)

- Arm Brace
- Arm Prothesis
- Leg Brace
- Leg Protheses
- Prosthetic Access
- Neck Brace
- Spinal Brace
- Foot Orthoses
- Walking Aids
- Walker
- Scooter
- Manual Wheelchair
- Electric Wheelchair
- Wheelchair
- Seating/Cushions
- Mechanical Lifts
- Lift Equipment
- Accessories
- Non-Mechanical Ramps
- Driving Equipment
- Van Lift
- Medical Supplies/Equipment
- Venilator/Breathing Assist
- Environmental Control Equipment
- Hearing Aids
- Vision Aid
- Commode
- Bath Seat
- Other: ______

Please indicate maintenance of devices (including battery charging of electronic devices):

MOBILITY AIDS
What type of mobility aid do you use?

Size & width of aid:

OTHER SERVICES

Do you require Attendant Service for Personal Care?  
- Yes  
- No
Type of personal care required: ______________________________

Have you made arrangements for care?  
- Yes  
- No

Do you require nursing or other professional services in addition to Attendant Service?

- No
- Require Periodic Visits – Specify service and frequency ______________________________________________________

Please indicate your AVERAGE DAILY level of Attendant Services required (choose one only):

- Less than 1 ½ hours
- 1 ½ to 3 hrs
- 3-5 hrs
- 5-7 hrs
- Greater than 7 hours

ATTENDANT SERVICE NEEDS

Do you require assistance with eating and meal preparation?  
- Yes  
- No
Do you require assistance with housekeeping, laundry, shopping?  □ Yes  □ No

Do you require assistance with sleeping, rising, dressing?  □ Yes  □ No

Do you require assistance with mobility?  □ Yes  □ No

Do you require assistance with physical control (e.g. administering medications), personal hygiene (e.g. bathing), personal care in the washroom (e.g. toileting)?  □ Yes  □ No

**DIET AND FOOD ALLERGIES:**
Please check (✓) any foods you are allergic to:

- Peanuts
- Tree Nuts
- Shellfish
- Milk
- Eggs
- Fish
- Soy
- Sesame Seed
- Sulfites
- Wheat
- Other food allergies not listed:
Do you require a specific diet? Please check (✔️) below:
- Bland/soft meal
- Diabetic meal
- Gluten-free meal
- Kosher meal
- Low-cholesterol/low-fat meal
- Low-sodium meal
- Non-lactose meal
- Other diet needs not listed:

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**ESSENTIAL COMMUNICATIONS** (check one for each method)

- Can you communicate verbally? [ ] Yes [ ] No
- Do you need assistance with the telephone? [ ] Yes [ ] No
- Do you need assistance with other communication aids? [ ] Yes [ ] No
- Do you require print materials in alternative formats (e.g. Braille)? [ ] Yes [ ] No

If required, what communication system(s) and/or aids do you use?

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**SERVICE ANIMAL**

- Do you use a service animal? [ ] Yes [ ] No

If yes, please describe the requirements for accommodating the needs of an animal

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**TRANSPORTATION**

- Will you be bringing your own vehicle? [ ] Yes [ ] No
- Do you have a Ministry Disabled parking permit? [ ] Yes [ ] No
- Will you be using Transhelp? [ ] Yes [ ] No
**ASSISTIVE TECHNOLOGY**

Please indicate what type of equipment you will be bringing and list the equipment requirements. (E.g. space, electrical outlets, etc.)

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer</td>
<td></td>
</tr>
<tr>
<td>Computer with large screen</td>
<td></td>
</tr>
<tr>
<td>Voice Recognition Software</td>
<td></td>
</tr>
<tr>
<td>Screen reader</td>
<td></td>
</tr>
<tr>
<td>Scanner</td>
<td></td>
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<tr>
<td>TTY</td>
<td></td>
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<tr>
<td>4-track tape recorder</td>
<td></td>
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<tr>
<td>Adjustable chair</td>
<td></td>
</tr>
<tr>
<td>Footrest</td>
<td></td>
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<tr>
<td>Visual Signaling Device (e.g. doorbell)</td>
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<tr>
<td>Other: ________________________________</td>
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</tbody>
</table>

**VISION/LIGHTING:**

Do you use Braille?  ❑ Yes  ❑ No

Do you require task lamps?  ❑ Yes  ❑ No

Please indicate light switch height requirements: ____________________________________________________________

**ACCESS TO UNIT**

Please indicate if you require any of the following:

An automatic door opener   ❑ Yes  ❑ No
A ramp at entrance        ❑ Yes  ❑ No

**WASHROOMS**

Is it important to you that you live in a house with two washrooms?  ❑ Yes  ❑ No
Required Aids
Please indicate what type of equipment you will be bringing/needng and list the equipment requirements. (E.g. space/height requirements, min. & max. height required for successful transfer, etc.)

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commode</td>
<td></td>
</tr>
<tr>
<td>Raised Toilet Seat</td>
<td></td>
</tr>
<tr>
<td>Bathtub transfer bench</td>
<td>Length:</td>
</tr>
<tr>
<td>Sink &amp; vanity</td>
<td>Height of counter:</td>
</tr>
<tr>
<td>Roll-In Shower Stall</td>
<td></td>
</tr>
<tr>
<td>Light Switches</td>
<td>Height:</td>
</tr>
<tr>
<td>Electrical Outlets</td>
<td>Height:</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td></td>
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</tbody>
</table>

**BEDROOM**

Do you need a larger than average single bed?  
- Yes  
- No  
Height of bed from floor__________  
Required height of study table__________  
Width of opening of study table__________  
Do you require a portable visual doorbell and fire alarm device?  
- Yes  
- No  
Do you have your own portable visual doorbell and fire alarm device?  
- Yes  
- No  
Other modifications required:

__________________________________________________________

**KITCHEN**

Do you require a mirror above the stove?  
- Yes  
- No  
Do you require electrical outlets at the front of the counter?  
- Yes  
- No  
Please indicate height specifications for: 
sink__________ stove__________ countertops__________ other:__________
Other modifications required:


ADDITIONAL COMMENTS:


Please provide any medical documentation that may assist in determining your needs in Residence to the AccessAbility Resource Centre, Room 2047, William Davis Building.

I understand that this information may be forwarded to the Manager/Disability Advisor of the AccessAbility Resource Centre and if food allergies/diet restrictions are indicated, to the Manager Retail Planning, Development and Operations for consultation. I am also aware that if building modifications are required, this information will be shared with the staff in the Facility Resources Department.

___________________________________  __________________________________
Signature                                      Date