UNIVERSITY OF TORONTO MISSISSAUGA

STUDENT HOUSING & RESIDENCE LIFE

ACCESSIBILITY NEEDS IN RESIDENCE

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

STUDENT INFORMATION

Name: Student Number:

Address:

Home Telephone:

Alternate Telephone: (❑ cell ❑ pager ❑ work)

E-mail: (must be @utoronto.ca)

Language: ❑ English ❑ French ❑ Sign language (ASL/LSQ)

Are you in receipt of funds from an insurance company for Attendant Services as a result of a settlement?
❑ Yes ❑ No

TYPE OF DISABILITY (please check all that apply)

- ❑ Acquired Brain Injury
- ❑ Amputation
- ❑ Arthritis/Rheumatic Conditions
- ❑ Low vision
- ❑ Blind
- ❑ Bone Disorders
- ❑ Brain Trauma
- ❑ Chronic Fatigue Syndrome
- ❑ Crohns Disease
- ❑ Colllitis
- ❑ Irritable Bowel Syndrome
- ❑ Cerebral Palsy
- ❑ Cystic Fibrosis
- ❑ Deaf
- ❑ Deafened
- ❑ Hard of Hearing
- ❑ Heart Condition
- ❑ Diabetes
- ❑ Diplegia
- ❑ Fibromyalgia
- ❑ Functional/Fine Motor
- ❑ Hemiplegia
- ❑ Hemophilia
- ❑ Mental Health (specify) _____
- ❑ Chronic Health Condition (specify) _____
- ❑ Mobility
- ❑ Monoplegia
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Muscular Disorders
- ❑ Neurological (non-progressive)
- ❑ Neurological (progressive)
- ❑ Paraplegia
- ❑ Quadriplegia
- ❑ Respiratory
- ❑ Spina Bifida
- ❑ Stroke
- ❑ Other: _____

EMERGENCY CONTACT PERSON

Name Address

Telephone Relationship

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 <u>one</u> 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:

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?

SERVICE ANIMAL

Do you use a service animal?	❑ Yes	❑ No

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

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.)

	Equipment	Requirements
❑	Computer	
❑	Computer with large screen	
❑	Voice Recognition Software	
❑	Screen reader	
❑	Scanner	
❑	TTY	
❑	4-track tape recorder	
❑	Adjustable chair	
❑	Footrest	
❑	Visual Signaling Device (e.g. doorbell)	
❑	Other: _____	

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/needing and list the equipment requirements. (E.g. space/height requirements, min. & max. height required for successful transfer, etc.)

	Equipment	Requirements
❑	Commode	
❑	Raised Toilet Seat	
❑	Bathtub transfer bench	Length: Width:
❑	Sink & vanity	Height of counter:
❑	Roll-In Shower Stall	
❑	Light Switches	Height:
❑	Electrical Outlets	Height:
❑	Other: _____	

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 Access*Ability* Resource Centre, Room 2047, William Davis Building

I understand that this information may be forwarded to the Manager/Disability Advisor of the Access*Ability* 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**