

## SHU Medical Evidence Proforma for DSA

Disabled Student Support, Level 5, Owen Building, Sheffield Hallam University,  
Howard Street, S1 1WB. Tel: 0114 225 3964, email: disability-support@shu.ac.uk

**To: GP for**

Dear Sir/Madam

**Re: Student:**  
**DoB:**  
**Address:**

We are making this request on behalf of the above named student who is in the process of applying for Disabled Student's Allowances from Student Finance England (SFE) or the NHS. In order for the funding body to declare the student eligible for these allowances they require the student to provide evidence of an impairment or medical condition which will impact on their capacity to undertake their studies effectively. Please could you therefore complete the attached form as a matter of urgency and return it to the address above so that we can support the student in making their application.

Yours faithfully,

Disabled Student Support

### **Student's Consent:**

I give consent for relevant confidential medical and/or personal information to be released to the Disabled Student Support Service at Sheffield Hallam University.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

**Please note that where a charge has to be made for the completion of this form, any request for payment should be made directly to the student.**



**Student Name:**

**Date of birth:**

<b>Organisation stamp (where available) and/or complement slip or headed paper attached</b>  <i>Medical evidence must be stamped/have headed paper in order to be accepted by the funding authority</i>	
<b>Organisation Address:</b>	

<b>Diagnosis / working diagnosis:</b> (If it is not possible to give a diagnosis or working diagnosis please explain why)					
<b>Has this condition lasted, or it is likely to last for 12 months or more? (answer required)</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>Impact on study and day to day activities</b> <i>(Please tick all that apply)</i>					
Attendance	<input type="checkbox"/>	Group Work	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Meeting deadlines	<input type="checkbox"/>	Note taking	<input type="checkbox"/>	Concentration	<input type="checkbox"/>
Organisation and Planning	<input type="checkbox"/>	Reading and research	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
Placement	<input type="checkbox"/>	Exams	<input type="checkbox"/>	Motivation	<input type="checkbox"/>
Pain	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	Memory	<input type="checkbox"/>
<b>Other impact/Additional information:</b>					

**Medical/Mental Health Professional Details**

<b>Job Title:</b>	
<b>The nature of your professional involvement with the student (if this is not apparent from your job title)</b>	

<b>Organisation Type:</b>			
GP Practice	<input type="checkbox"/>	Hospital Based Mental Health Team Other (please specify)	<input type="checkbox"/>
Primary Care Mental Health Team (including IAPT services)	<input type="checkbox"/>	Other (please specify):	<input type="checkbox"/>
Secondary Care Mental Health Team (including EIP, Crisis Teams, Community Mental Health teams etc)	<input type="checkbox"/>		

**Name** \_\_\_\_\_ **(PLEASE USE BLOCK CAPITALS)**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

