APPENDIX B:
DRAFT WRITTEN ASSESSMENT QUESTIONNAIRE: DISABILITY[9]

NSFAS

HEI logo

Note:
All students with disabilities applying for financial aid need to complete this form upon initial application for financial aid. Should the nature of the disability change over the term of the study, and if this impacts directly on the students' ability to participate in his/her educational programme, then the student will need to submit updated details and a full medical/rehabilitation report from a certified professional.

Failure to provide the information requested on all pages will render this application incomplete.

Please complete in detail, in legible handwriting for certification and verification by a registered healthcare professional.

The completion of this section by the higher education institution prior to the referral of the student to a medical/rehabilitation professional is compulsory.

STUDENT DETAILS

Student number:

Student name (title, surname, first name):

_____

Identity Number:

Contact numbers:
(h) _____

(cell) _____

HIGHER EDUCATION INSTITUTION DETAILS

Referring University/University of Technology:

_____

Financial Aid Officer Name:

_____
Contact number:

Disability Support Unit Officer Name:

_____
Contact number:

Please indicate the following (for office purposes only):	
Is the student currently receiving a disability grant/care dependency grant?	YES/NO
Has the student made application for a grant?	YES/NO
Is the student on a medical aid? (as main member or dependent)	YES/NO

The following sections must be completed by a registered medical practitioner or rehabilitation professional:

Name of medical practitioner/rehabilitation professional: _____

Name of medical practice/hospital: _____
(please indicate if state/private)

Practice number (if in private practice): _____

HPCSA registration number: _____

[9] All information contained in this form will remain with the university/university of technology and/or NSFAS only and will remain confidential.

GENERAL STUDENT/CLIENT DETAILS:

Diagnosis: _____

_____

_____

Has the condition been present since birth? YES/NO

If not, please indicate date and reason for onset: _____

_____

Present symptoms/defining features: _____

_____

_____

Prognosis: _____

_____

_____

(please indicate if condition likely to deteriorate/improve over the next 3 - 5 years, and if so, how will impact on the student)

Clinical Summary: (please include relevant investigations, reports, interventions - both surgical and non-surgical/rehabilitative):

_____

_____

_____

_____

_____

Special needs with respect to assistive devices, or other:

_____

_____

_____

Is the student on medication? YES/NO
If yes, will this need to be continued while studying, and is it self-administered?

_____

What is the students' level of dependence in respect of the following aspects:

	Totally dependent	Assistance required	Supervision	Independent
• Eating	☐	☐	☐	☐
• Dressing	☐	☐	☐	☐
• Washing	☐	☐	☐	☐

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- Toileting ☐ ☐ ☐ ☐
- Walking ☐ ☐ ☐ ☐

Have there been any rehabilitation interventions specifically in the past? YES/NO
Please provide further details (treatment given, progress made, period of treatment).

_____

_____

_____

_____

Did the student attend a special school and receive rehabilitation while at school? YES/NO
If so, which school and what was the nature of the programme?

_____

_____

Name of current physiotherapist/occupational therapist: _____

Contact details: _____

Is the student a wheelchair user? YES/NO
Is yes, is this self-propelled ☐ or does the student require support to use wheelchair ☐ ?
Can the student transfer in/out of the wheelchair independently ☐ or with physical help ☐ ?
Ownership of the wheelchair: bought ☐ renting ☐ on loan ☐ state hospital ☐ other ☐

Does the student require any other additional mobility assistive devices? YES/NO
If yes, please provide additional details:

_____

_____

Is the student using hearing aids? YES/NO
If yes, please give a short description of the hearing aids currently being used by the student:

_____

_____

Name of current audiologist: _____

Contact details: _____

Is the student using any other communication devices? YES/NO
If yes, please give a short description of the communication devices currently being used by the student:

_____

_____

Name of current speech therapist: _____

Contact details: _____

Is the student using glasses or other visual aids? YES/NO
If yes, please give a short description of the visual aids (glasses or other) currently being used by the student:

_____

_____

Name of optometrist/eye specialist: _____

Contact details: _____

FINAL DIAGNOSIS AND RECOMMENDATIONS:

(student name) _____ is identified as having (diagnosis) _____ which is a disability/impairment that is physical/visual/hearing/communication (please delete whichever relevant) in nature, and this disability/impairment is long-term, recurring and substantially limiting.

His/her application for financial aid for students with disabilities at (name of higher education institution) _____ is supported through the medical history, interventions and information contained in this brief report.

In addition, it is recommended that consideration be given to the provision of required assistive devices (as indicated) _____ within the maximum amounts allowable through the bursary scheme.

_____ _____
NAME DATE

_____
SIGNATURE

Stamp:
Medical practice/hospital