FUNCTIONAL LIMITATION ASSESSMENT FORM

Regulated Health Care Professional's Guide to Completing the Functional Limitation Assessment Form for Post-Secondary Students with a Disability.

STUDENT SECTION

This section is to be completed and signed by the student PRIOR TO asking a health care professional to complete this form.

Consistent with the Ontario Rights Commission, **students are not required to disclose their disability diagnosis** in order to register with Health, Wellness, and Accessibility Services (HWAS) and to receive academic accommodations. Students are encouraged to discuss their diagnosis and how it impacts their learning with the Accessibility Consultant as the Consultant plays a vital role in the planning and implementation of the individual accommodation process.

Important Notes to Students

1. Students must provide written consent for the information on the completed form to be shared with HWAS.
2. Students must share any existing documentation related to their learning (such as psychoeducational assessments or medical documentation) with HWAS.
3. In some cases, it may be necessary to obtain additional information to help with accommodation planning.
4. In some cases, temporary academic accommodations may be provided to students without documentation of a functional limitation or a disability. These academic accommodations are implemented while students are collecting documentation to inform an individual accommodation plan.

To Be Completed by Student:

_____ _____

Last Name First Name Student Number

_____ _____

Date of Birth Phone Number

_____

Email address

Student Consent for Release of Information:

I, _____ hereby authorize the health practitioner to provide the information contained in this form to Accessibility Services at Niagara College Toronto, if required, to provide additional information related to my disability. I also authorize Accessibility Services to contact the health care practitioner to discuss the provision of academic accommodations.

_____ _____

Student Signature Date

Check one:

☐ I consent to the disclosure of the diagnosis of my disability

☐ I do not consent to the disclosure of my disability

_____ _____

Signature of Student Date

REGULATED HEALTH PROFESSIONAL SECTION

This section is to be completed and signed by a Regulated Health Care Practitioner (Please print clearly).

Approved Professionals
Any of the following professionals who are licensed to practice in the Province of Ontario may complete this form:

Family Physician	Medical Specialist	Nurse Practitioner
Chiropractor	Physiotherapist	Optometrist
Audiologist	Speech-Language Pathologist	Psychologist

Submission to the College
Please complete the form and return it to the student for submission to Health, Wellness, and Accessibility Services at their campus. It is the student's responsibility to submit this completed form.

Note to Practitioner:
This form contains many sections. Professionals are asked to complete only those sections that relate to their scope of practice. Please complete your assigned section(s) as thoroughly as possible, based on your scope of practice and knowledge of the student.

This student has been my patient for:

☐ More than 2 years ☐ Less than 2 years ☐ Walk-in / first visit

Section 1: Functional Limitation / Disability Status

The following criteria must be met for the determination of a disability:

1. The student experiences functional limitation(s) due to a health condition; and
2. The functional limitation(s) impairs the student's academic functioning.

☐ I confirm that this student has a disability based on a diagnosed health condition according to the criteria outlined above

☐ I am monitoring this student's condition to determine a diagnosis

Duration of the Disability – Complete 1, 2, or 3 below.

1. This student has a **permanent disability** with symptoms that are:

   ☐ Continuous ☐ Recurrent/episodic

2. This student has a **temporary disability** with symptoms that are: *

   ☐ Continuous ☐ Recurrent/episodic

Accommodations to be provided from _____ to _____
Date Date

3. This student is being monitored to determine a diagnosis. *

Accommodations to be provided from _____ to _____
Date Date

***Updated documentation will be required by the College after the end date.**

DIAGNOSIS: _____

Section 2: Medications

If the student has been prescribed medication for a condition, when is the medication likely to affect their academic functioning negatively? (Check all that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ N/A

For students with Seizure Conditions (if applicable):

Frequency of Seizures (Please check one of the following):

☐ Daily ☐ Weekly ☐ Monthly ☐ Rare

Medication and dosage/administration*: _____
_____
_____

***NOTE: Students must administer their own medication.**

Section 3: Assessing Functional Impact in a Post-Secondary Setting

Please use the chart below to indicate the impact of a disability/medication side-effects on the various areas of functioning.

Skills / Abilities	No Impact	Mild Impact	Moderate Impact	Severe Impact	Not Sure
COGNITION					
Attention / Concentration					
Long-term Memory					
Short-term Memory					
Executive Functioning					
Information Processing					
Ability to Manage Distractions					
Judgment – anticipating the impact of one's behaviour on self and others					
Other:					
PHYSICAL					
Class attendance in person					
Stamina (ability to complete a full course load)					
Mobility					
Gross motor					
Fine motor					
Ability to sit for sustained period					
Ability to stand for sustained periods					
Other:					
SENSORY (Provide Additional Information Below)					
Vision (best corrected)					
Hearing (best corrected)					
Speech					
SOCIAL / EMOTIONAL					
In-class group work / interaction					
Ability to perform class presentations					
Reading social cues					
Ability to manage stress in class					
Ability to manage stress in tests					
Effectively control emotions					
Other:					

Additional Comments or Elaboration

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section 4: Health Practitioner Authorization

Date Completed (YYYY/MM/DD): _____

Practitioner's Name (please print): _____

Practitioner's Signature: _____

Practitioner's License #: _____

Practitioner's Address & Phone Number: _____
_____

Office Stamp Required