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

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 Human Rights Commission, students are not required to disclose their disability diagnosis in order to register with Accessible Education Services and to receive academic accommodation. However, the Ontario Human Rights Commission recognizes that Disability Services Offices have expertise in dealing with accommodation issues in the academic environment, and as such, play a vital role in the planning and implementation of the individualized accommodation process. Students who want to disclose their diagnosis to their Fleming Counsellor in Accessible Education Services may do so.

It is also important that you know that government funding programs such as OSAP and the Bursary for Students With Disabilities currently **DO** require that you provide disability documentation that includes your diagnosis.

If you have a learning disability, you will need to provide Fleming's Counselling & Accessible Education Services department with a copy of your psychoeducational assessment. If you have concerns about this or do not have a psychoeducational assessment, please discuss this with your counsellor.

Check one:
☐ **I Do** ☐ **I Do NOT** **consent to disclose the diagnosis of my disability**

_____
Signature of Student:

Please Print:
Student's Last Name: _____

Student's First Name:_____

Date of Birth(mm/dd/yyyy):_____

Student Number: _____

Address: _____

_____

Phone (Home/Cell): _____

Email Address: _____

Functional Limitations Assessment Form

Dear Health Care Practitioner,

You have been asked by a Fleming College student to complete the attached documentation. This is needed for the student to access academic accommodations. The purpose of this form is to provide a system-wide approach for Regulated Heath Care Professionals in Ontario to document the functional limitations that a student with a disability is likely to experience at college or university. The information you provide will help the student and their counsellor to assess the student's eligibility for academic and/or access accommodations.

Students must provide written consent for you to share the information on the completed form with the Fleming College's Counselling & Accessible Education Services. Please note in some cases it may be necessary to obtain additional information. If further information is required, the student will again need to provide written consent for the release of that information.

Any information sought should clearly relate to accommodation planning.

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

Family Physician	Medical Specialist	Psychiatrist	Psychologist
Optometrist	Audiologist	Ophthalmologist	Psychological Associate
Nurse Practitioner	Chiropractor	Occupational Therapist	
Speech-Language Pathologist			

Since this form contains many sections, professionals are asked to complete only those section(s) that relate to their scope of practice. Please complete your assigned section(s) as thoroughly as possible based on your knowledge of the student. Please see below for specific scope of practice areas.

What if I Can't Complete Certain Sections of the Form?

This form was designed to mirror the **Ontario Disability Support Program f**orm with the goal of making the format familiar to Regulated Health Care Professionals. Only rate those skills/abilities that in your professional opinion have disability-related functional limitations in an academic environment. Examples of the academic demands required of a student in the post-secondary setting are provided on the form for your guidance.

Payment

Currently there is no set fee for the completion of this form, however, it would be similar to the fee ($80) charged for completing the Health Status Report for ODSP purposes.

Submission to the College

Please complete the form and return it to the student for submission to the Counselling Office at their campus of Fleming College.

Functional Limitations Assessment Form for Post-Secondary Students with a Disability

Student's Last Name _____ Student's First Name _____

Student Number (if known) _____ D.O.B _____

The following criterion must be met:

The student experiences functional limitations due to a health condition that impairs the student's academic functioning at a learning and/or access level while pursuing post-secondary studies.

I confirm that:

- ❑ this student has a disability based on a diagnosed* health condition according to the criterion outlined above, or
- ❑ I am monitoring this student's condition to determine a diagnosis

If the students has consented to disclosure of their specific diagnosis(es) to their Fleming counsellor (as indicated by their signature on page 1) please provide the diagnosis(es) here:

*According to the Ontario Human Rights Commission, post-secondary institutions do not routinely need to be informed of the specific diagnosis to provide academic accommodation. Ontario Human Rights Commission, *Policy on preventing discrimination based on mental health disabilities and addictions* (Toronto: Government of Ontario, 2014), section 13.7 at 53.

Duration of the Disability

Complete 1 or 2 or 3

1. This student has a **permanent disability** with symptoms that are:
   ❒ continuous OR ❒ recurrent/episodic

2. This student has a **temporary disability** with symptoms that are:
   ❒ continuous OR ❒ recurrent/episodic

   Accommodations to be provided from _____ to** _____

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

   Accommodations to be provided from _____ to** _____

**Updated documentation will be required by the institution after this date.

Medication

If the student has been prescribed medication for this condition, when is the medication likely to affect academic functioning negatively? (Click all that apply)
❒ Morning ❒ Afternoon ❒ Evening ❒ N/A

Using the scale, please rate the impact of the impairment and possible medication effects (if any) on the areas of functioning listed below.

Sections A, B, C and D to be completed by the following:

Family Physician Medical Specialist Psychologist
Psychological Associate Psychiatrist

A. Cognitive Skills/Abilities					
	1 **Within normal limits** No functional limitation evident in this area	**2** **Mild or slight** Functional limitation evident in this area	**3** **Moderate** Functional limitation evident in this area	**4** **Severe** Functional limitation evident in this area	**5** Unable to assess or unknown at this time
Attention/Concentration (e.g. during exams, classes labs; while writing essays/ reports)					
Short -Term Memory (information that is stored for about 30 seconds; e.g., ability to follow class directions)					

A. Cognitive Skills/Abilities					
Long-Term Memory (e.g., ability to recall and retrieve stored information especially in time-limited testing situations)					
Information Processing (e.g., ability to input, process, store and retrieve information)					
Manage Distractions (e.g., ability to filter out distracting visual and auditory stimuli during classes and/or testing situations)					
Executive Functioning: Planning, Organizing, Problem Solving, Sequencing, Time-Management (e.g., ability to: meet exam/assignment deadlines; multi-task {e.g., listen and take notes at the same time}; prioritize academic tasks {e.g., complete assignments, study, attend classes}; manage time effectively {e.g., stay focused on task})					
Judgment: anticipating the impact of one's behavior on self and others (e.g., understand when it is an appropriate time to interrupt a professor in class)					
Communication (the ability to effectively convey and receive information orally or in writing)					
Other: Please describe					
Comments – please elaborate on any of the areas above that need further explanation:					

Sections A, B, C and D to be completed by the following:

Family Physician | Medical Specialist | Psychologist
Psychological Associate | Psychiatrist

B. Physical Skills/Abilities					
	1 **Within normal limits** No functional limitation evident in this area	**2** **Mild or slight** Functional limitation evident in this area	**3** **Moderate** Functional limitation evident in this area	**4** **Severe** Functional limitation evident in this area	**5** Unable to assess or unknown at this time
Mobility (e.g., ability to: get to and from classes/fieldwork independently; ambulate within classroom, lab, placement environment, etc; climb stairs; maintain balance)					
Gross Motor (e.g., ability to: lift, carry, reach overhead, twist, bend, kneel)					
Fine Motor/Manual Dexterity (e.g., ability to: grip pencil/pen and write; type; perform repetitive activities; operate precision instruments such as a microscope; manipulate tools safely {e.g., scissors, screwdrivers, tweezers, saws, drills, etc.})					
Stamina/Ability to engage in academic activities (e.g., ability to attend 15^{+} hours of classes per week, complete the resulting study requirements and meet assignment and exam demands)					
Sit for sustained periods of time (e.g., during a 3 hour lecture or while on placement)					
Stand for sustained periods (e.g., during a 3 hour lab or while on placement)					
Other: Please describe					
Comments – please elaborate on any of the areas above that need further explanation:					

B. Physical Skills/Abilities

Sections A, B, C and D to be completed by the following:

Family Physician
Psychological Associate
Medical Specialist
Psychiatrist
Psychologist

C. Social-Emotional Skills/Abilities					
	1 **Within normal limits** No functional limitation evident in this area	**2** **Mild or slight** Functional limitation evident in this area	**3** **Moderate** Functional limitation evident in this area	**4** **Severe** Functional limitation evident in this area	**5** Unable to assess or unknown at this time
Effectively control emotions during routine academic interactions (e.g., work cooperatively and collaboratively during in-class group work situations; be calm when interacting with others {professors, students fieldwork clients}, ability to approach professors when needed)					
Effectively read social cues (e.g., follow established classroom protocols such as wait to be asked before answering professor's question, understand when is an appropriate time to interact with others)					
Effectively control emotions during evaluation situations (e.g., sit in assigned seating during exams/tests with the rest of the class; deliver oral presentations to peers/professors; accept constructive feedback on performance without adverse reaction)					
Ability to effectively manage the demands of academic life (e.g., pressures of multiple assignments, readings, tests/exams; being away from home; placement					

C. Social-Emotional Skills/Abilities					
expectations)					
Participate appropriately during in-class and group work situations (e.g., participate in classroom discussions, collaborate with peers on group assignments)					
Ability to respond to change effectively (e.g., change of: classrooms, assignment deadlines, class schedule, professors)					
Other: Please describe					
Comments – please elaborate on any of the areas above that need further explanation:					

Sections A, B, C and D to be completed by the following:

Family Physician
Psychological Associate
Medical Specialist
Psychiatrist
Psychologist

D. Fieldwork-Specific Skills/Abilities ❒ Fieldwork is required by the student's program of study (Complete this section) ❒ Fieldwork is not required by the student's program of study (Skip to Section E)					
	1 **Within normal limits** No functional limitation evident in this area	**2** **Mild or slight** Functional limitation evident in this area	**3** **Moderate** Functional limitation evident in this area	**4** **Severe** Functional limitation evident in this area	**5** Unable to assess or unknown at this time
Work safely with vulnerable populations (people who are ill, people with disabilities, children and older adults)					
Stamina: Meet the demands of fieldwork (e.g., 35+ hours of fieldwork per week, possible 12-hour					

D. Fieldwork-Specific Skills/Abilities ❒ Fieldwork is required by the student's program of study (Complete this section) ❒ Fieldwork is not required by the student's program of study (Skip to Section E)					
shifts; day, evening or night shifts)					
Other: Please describe					
Comments – please elaborate on any of the areas above that need further explanation:					

Section E to be completed by the following:

Family Physician Optometrist Ophthalmologist

E. Vision					
	1 **Within normal limits** No functional limitation evident in this area	**2** **Mild or slight** Functional limitation evident in this area	**3** **Moderate** Functional limitation evident in this area	**4** **Severe** Functional limitation evident in this area	**5** Unable to assess or unknown at this time
Vision Visual acuity loss (best corrected), left eye, right eye, bilateral, visual field limitations					
Comments – please elaborate on any of the areas above that need further explanation:					

Section F to be completed by the following:

Family Physician Audiologist

F. Hearing					
	1 **Within normal limits** No functional limitation evident in this area	**2** **Mild or slight** Functional limitation evident in this area	**3** **Moderate** Functional limitation evident in this area	**4** **Severe** Functional limitation evident in this area	**5** Unable to assess or unknown at this time
Hearing (Hearing Loss (best corrected), left ear, right ear, bilateral)					
Comments – please elaborate on any of the areas above that need further explanation:					

Section G to be completed by the following:

Speech Language Pathologist Family Physician

G. Speech					
	1 **Within normal limits** No functional limitation evident in this area	**2** **Mild or slight** Functional limitation evident in this area	**3** **Moderate** Functional limitation evident in this area	**4** **Severe** Functional limitation evident in this area	**5** Unable to assess or unknown at this time
Speech					
Comments – please elaborate on any of the areas above that need further explanation:					

Section H to be completed by the following:

Family Physician Medical Specialist

H. Safety

Does this student have a condition such that the college/university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork, (e.g. seizure disorder, severe allergic reaction)

❒ Yes ❒ No

If “yes”, please describe condition(s)

Comments:
Please elaborate on any of the areas above that need further explanation

Section I to be completed by any of the professionals listed in the above sections:

I. Specialized Equipment and Services

Based on the functional limitations you identified above, is there a need for specialized equipment and/or services? If the answer is “yes”, please

(i) select items required and
(ii) provide a rationale as to why the specialized equipment or service is needed.

Specialized Services:

❒ Sign language interpretation ❒ Computerized note taker

❒ Documents in braille ❒ Large print

❒ Accessible textbooks, readings

Other, please specify

Classroom modifications:

❒ Ergonomic furniture ❒ Assigned seating

Assistive technologies:

❒ Use of a screen reader ❒ Voice to text software ❒ Specialized lighting

❒ Magnification equipment ❒ Text to voice software ❒ Laptop

❒ Amplification system ❒ Video captioning

Other, please specify

Rationale for Specialized Services/Equipment:

Certificate of Approved Professional

Name:	
Stamp or Business card (image of hard copy)	
Address:	
Postal Code	
Phone Number	
Fax Number	
Email Address:	
License Number/ Registration Number	

I _____ am a legally qualified _____ in the province of Ontario and this report contains my clinical assessment and considered opinion of at this time.

_____ _____

Signature Date

Student Consent

I give consent for my counsellor at Fleming College to contact my medical practitioner or registered psychologist to discuss the information provided in this document.

Student's Signature: _____

Date: (mm/dd/yyyy): _____

****Note to student:** If you have other relevant documentation, you may include copies of it with this registration package. These additional documents are not intended to replace the Disability Documentation form. Please note - additional documentation may be requested