CENTRE LABELLE
Évaluation et intervention psychosociale

Université de Hearst

75 Queen Street, Kapuskasing ON
centrelabellecentre@uhearst.ca
www.centrelabellecentre.ca
Tel. : (705) 335-5588

Functional Limitations Form

(Inspired by Student Accessibility Services Documentation Form created by NOARC/CERNO)

This form is designed to provide the Centre Labelle Centre with confirmation that you have a disability and with information on how your disability will impact you while studying at Université de Hearst.

PART A – To be completed by the student

The mandate of the Accessibility office, informed by the Ontario Human Rights Code, is to provide individualized academic accommodations to equalize learning opportunities. The Accessibility office will use the information provided by your health care provider to work with you to determine what accommodations you will need while you are studying at Université de Hearst. The regulated health care professional who completes this form will be asked to use their assessment and detailed knowledge of you to describe the functional impact of your disability.

Please complete Section A and ask a health care professional who knows you well to complete Section B. Once completed, please send the form (both sections) to accessibilite@uhearst.ca.

NOTE : Disclosure of a diagnosis is a choice and it is not required to receive accommodations from the Accessibility office. Any information provided on this form is kept strictly confidential and will not be shared with anyone outside of the Accessibility office without your explicit written consent.

STUDENT INFORTMATION

First and last name: Date of birth:
Email address: Phone number:

CONSENT TO RELEASE INFORMATION

I, ____, authorize my health care professional to provide information outlined in this form, as well as any other relevant information to Université de Hearst's Accessibility office.

CONSENT TO DISCLOSURE OF DIAGNOSIS

☐ I **consent** to my diagnosis being identified on this form and provided to Université de Hearst's Accessibility office.

☐ I **do not consent** to my diagnosis being identified on this form and provided to Université de Hearst's Accessibility office.

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PART B – To be completed by the Health Care Professional[1]

You are being asked to complete the following Documentation Form by a student who wishes to register with Université de Hearst's Accessibility services. We seek the following information:

1) **confirmation that the student has a disability**, and
2) **confirmation of functional limitations the student experiences directly related to their disability or health condition**.

We rely on your assessment and detailed knowledge of this student and their disability to provide us with a description of the current functional limitations that impact the student in the academic context. Please use the form that follows to identify the functional limitations that impact the student in the academic context. In some cases, students will complete the Functional Limitations section themselves. If this is the case, we ask that you initial each functional limitation indicated by the student with which you agree. By initialling in agreement, you are indicating that you have assessed this functional limitation and are in agreement that the limitation is present OR based on your knowledge of the student's condition, this limitation is related to the student's diagnosed disability(ies).

The information you provide, along with the information provided by the student, will be used by the Centre Labelle Centre in collaboration with Université de Hearst to design an individualized accommodation plan. This plan helps to ensure the student has an equitable opportunity to fulfill the essential academic requirements and standards at Université de Hearst.

Disclosing a diagnosis is not required to access accommodations from the Accessibility office. **You are asked to only provide a diagnosis with the student's consent** (see the first page of this form). Any information provided on this form will be kept strictly confidential and will not be shared with anyone outside of the Accessibility office without the student's explicit consent.

All pages must be completed. Please return the completed form to the student.

1. REGULATED HEALTH CARE PROFESSIONAL INFORMATION

First and last name:
Registration number:
Fax number:
Phone number:

OFFICIAL PRACTICE STAMP BUREAU*

☐ Physician – Family
☐ Physician - Specialty (specify):
☐ Psychologist/Psychological Associate
☐Other Regulated Health Professional (specify):

*(If you do not have an official stamp, please sign, date, and attach a sheet of your Office Letterhead.)

[1] Only the Health Care Professionals who are authorized to give a diagnosis can complete this form.

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2. CONFIRMATION OF DISABILITY

The following criterion must be met for the determination of a disability:
The student experiences functional impairments due to a disability or diagnosed health condition that impacts the student's academic functioning while pursuing postsecondary studies.

Duration of disability: *The designation of permanent disability has legal implications and is used in determining a student's eligibility for government programs.* ☐ **Permanent disability** - ongoing, will impact the student over the course of their academic career, and is expected to remain for the person's lifetime ☐ **Ongoing disability** – duration unknown ☐ **Temporary disability** Anticipated duration: ☐ **Diagnosis unconfirmed*** - additional assessment is required Assessment likely to be completed by: Next clinical assessment appointment:

*Interim accommodations offered under these circumstances may require periodic documentation from professionals.

Diagnosis:
If the student consented to sharing their diagnosis (see the first page of this form), please indicate it here:

Expected changes in level of functioning: ☐ Condition is expected to remain **stable** ☐ Condition is expected to **decline**	☐ Condition is expected to **fluctuate significantly** ☐ Changes in level of functioning are **difficult to predict**	
Does this student have a disability that is episodic in nature (i.e., with periods of good health)?	☐ Yes ☐ No	
If the student's functioning is restricted at certain times of the day? Please specify when:	☐ Morning ☐ Afternoon	☐ Evening ☐ Not applicable

3. FONCTIONAL LIMITATIONS

Please check all functional limitations the student experiences specifically due to their disability. Please indicate your initials as well.

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COMMUNICATION ☐ Not applicable		
Condition significantly restricts ability to:	**Yes**	**Health Care Professional initials**
Organize and communicate ideas in written form	☐	
Organize and communicate ideas verbally	☐	
Present orally to a group or class	☐	
Participate in large class (i.e., 10 or more)	☐	
Participate in online discussions	☐	
Participate in small groups	☐	

COGNITIV FUNCTIONNING ☐ Not applicable		
Condition significantly restricts ability to:	**Yes**	**Health Care Professional initials**
Recall information after a delay (long-term memory)	☐	
Recall information that is stored for a short period of time (short-term memory)	☐	
Hold and manipulate information (working memory)	☐	
Complete a series of academic tasks scheduled in close sequence (i.e., several assignments/tasks in the same week, multiple exams in one day)	☐	
Complete a timed academic task	☐	
Process written or verbal information	☐	
Interpret and follow instructions	☐	
Maintain focus on academic tasks in a setting with visual distractions	☐	
Maintain focus on academic tasks in a setting with auditory distractions	☐	
Organize, sequence, and prioritize academic tasks	☐	
Plan and set goals to meet deadlines	☐	
Read for up to 3 hours	☐	
Complete cognitively straining tasks for up to 3 hours	☐	

SOCIAL/EMOTIONAL FUNCTIONNING ☐ Not applicable		
Condition significantly restricts ability to:	**Yes**	**Health Care Professional initials**
Effectively read social cues (i.e., following classroom protocols)	☐	
Regulate emotions (all while interacting with others in the class as well as the professor, accepting constructive feedback)	☐	
Complete academic tasks while being evaluated (i.e., exams, placement)	☐	
Respond to changes in classrooms, assignment deadlines and class schedules	☐	
Participate in group or lab activities with assigned or chosen peers (i.e., work with a group or partner to achieve a goal)	☐	
Ensure appropriate behaviour in the classroom (i.e., limit verbose and disruptive behaviour)	☐	
Maintain personal hygiene (i.e., body odour)	☐	

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SENSORY SENSITIVITIES ☐ Not applicable		
Condition significantly restricts ability to:	**Yes**	**Health Care Professional initials**
Use of a computer for academic purposes	☐	
See the whiteboard/projector in a lecture hall	☐	
See regular print (i.e., 12 pt. font) on a computer screen or on paper	☐	
Hear the professor in a large lecture hall (even with the use of a microphone)	☐	
Hear other individuals in a small classroom setting	☐	
Hear conversations in a setting with background noise	☐	
Hear dialogue in videos, process live dialogue during online class discussions	☐	
Process visual stimuli (i.e., sensitivity to light, certain colours)	☐	
Process auditory stimuli (i.e., sound sensitivities)	☐	
Process tactile or olfactory stimuli (i.e., touch/texture and smell sensitivities)	☐	
PHYSICAL FUNCTIONNING ☐ Not applicable		
Condition significantly restricts ability to:	**Yes**	**Health Care Professional initials**
Walk to, from, and between classes with backpack and books/computer	☐	
Handle and manipulate small objects (fine motor movement)	☐	
Handwrite for up to 3 hours	☐	
Sit for up to 3 hours or more	☐	
Regulate motor activity (i.e., need to move or fidget)	☐	
PRESENTATION OF DISSABILITIY(IES) ☐ Not applicable		
Condition significantly restricts ability to:	**Yes**	**Health Care Professional initials**
Attend classes and arrive on time	☐	
Complete tests/exams on the date they are scheduled (i.e., impairment is characterized by periods of ill health)	☐	
Complete assignments on time when given advanced notice	☐	
Complete a post-secondary full-time course load: 18-24 hours per week	☐	
If applicable, improvement is expected within: week(s)		☐ Not applicable
OTHER FONCTIONAL LIMITATIONS		

If the student self-reported functional limitations, the health care professional agrees that limitations are directly related to the student's disability/disabilities. ___________ (**initials**)

I confirm that the student would benefit from support in the areas indicated. ___________ (**initials**)

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4. TREATMENT PLAN

How long have you been treating the student:
Date of disability identification:

The confirmation of disability is based on (**choose A or B**):

A. ☐ I have recently assessed this student and am knowledgeable about their disability and related functional impairments.

B. ☐ I have expertise in this area of disability and have reviewed current documentation provided by this student that gives a detailed assessment of their disability and related functional impairments.

Date of most recent assessment (related to this disability(ies)):

Will you remain involved in ongoing management and treatment of this student's disability? ☐ **Yes** ☐ **No**

If yes, how often:
If no, does the student require ongoing care:

Treatment Plan (i.e., recommended follow-up, referrals, specialized equipment, accommodations):

Does the individual take any medications that could negatively impact their academic functioning?
☐ **Yes** ☐ **No**

If no, please proceed to the "Other Information" section.
If yes, when are the side effects of any prescribed medication likely to occur (check all that apply):
☐ **Morning** ☐ **Afternoon** ☐ **Evening**

Medication level of impact on academic functioning:
☐ **Mild** ☐ **Moderate** ☐ **Severe**

Please list side effects of medication(s) which may impact academic functioning:

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5. OTHER INFORMATION

Other pertinent information related to the student's disability or functioning in the academic context:

6. AUTHORIZATION

Health Care Provider's Signature

Date