FUNCTIONAL LIMITATION VERIFICATION FORM

AccessAbility Services - University of Waterloo
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TO BE COMPLETED BY STUDENT

This form is to be completed by you and your practitioner (e.g. Occupational Therapist, Social Worker, Speech-Language Pathologist, traditional healer) who has in-depth knowledge of your functional limitations. The purpose is to identify functional limitations that are causing barriers in the academic environment, which may require an academic accommodation. This form is most appropriate for individuals where a disability diagnosis has not been, or may not be, established, yet there is a presence of functional limitations that may impact your academics. (Note: If a formal diagnosis has been established, you may choose to have the disability specific verification for completed instead. The other forms are available here: https://uwaterloo.ca/accessability-services/students/applying-academic-accommodations/disability-verification

This form will be used to identify functional limitations that require accommodations in the academic environment. Please upload this form with your online application to AccessAbility Services: https://uwaterloo.ca/accessability-services

SECTION 1: STUDENT INFORMATION

Student information (please print)	
Last name:	
First name:	
Date of birth (DD/MM/YYYY):	
Waterloo ID number:	
Phone number (home/cell)	
Waterloo e-mail address:	@uwaterloo.ca

SECTION 2: CONFIDENTIALITY & AUTHORIZATION FOR RELEASE OF INFORMATION

Information provided in this form, is kept ***strictly confidential***. It is not shared with anyone outside of AccessAbility Services, including with other university departments, without the expressed and written consent and/or direction of the student. Please note that your practitioner will also maintain a copy of this document in your file with them.

By submitting this form, I authorize the attending health care professional named in this form to complete the Functional Limitation Verification Form and disclose information concerning myself to AccessAbility Services.

By signing below, I give consent for AccessAbility Services to contact the service provider who completed this form to discuss information provided in this document, if necessary, to clarify information regarding functional limitations or if there are questions related to my application.

Student's signature:	Date completed (DD/MM/YYYY): ___________________________

Student's informed authorization for disclosure of information is obtained in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), -s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

TO BE COMPLETED BY HEALTH CARE PRACTITIONER

SECTION 3: ASSESSMENT INFORMATION

1. Are there functional limitations related to any of the following?
   ☐ Physical disability/condition
   ☐ Mental health disability/condition
   ☐ Acquired brain injury (e.g. concussion)
   ☐ Hard of hearing disability/condition
   ☐ Visual disability/condition
   ☐ Other: ____

   ***This form is not intended for a learning disability diagnosis. Instead, student should be directed to submit a copy of their psycho-educational assessment.**

2. Diagnosis(es): ____

   Name of Qualified Practitioner*: ____

   Position/Title: ____

   ***Please only include this information when the diagnosis(es) was established by a practitioner legally qualified to do so (e.g. Physician, Psychologist).**

3. Please indicate (if known) the onset of the student's functional limitations (i.e., when the student began experiencing symptoms and challenges in the academic environment): ______________________________

4. How long have you been **regularly** evaluating the student for the presenting concerns? __________________

5. How many times have you assessed the student for the presenting concerns? __________________________

6. Will you be monitoring/treating the student while they are at University? ☐ Yes ☐ No

SECTION 4: DURATION OF ASSOCIATED FUNCTIONAL LIMITATIONS

☐ **Permanent, continuous:** Ongoing functional limitations that will impact the student over the course of their academic career and are unlikely to change

☐ **Permanent, episodic:** Periods of good health interrupted by periods of illness or disability over the course of their academic career

☐ **Temporary:** These functional limitations are temporary, or the severity may change, and should be reassessed in the future. Student to be reassessed by: ______________________ (DD/MM/YYYY)

☐ **Provisional:** I am still monitoring/assessing the student. Assessment is likely to be completed by: ______________________ (DD/MM/YYYY)

☐ **No disability:** The symptoms do not constitute a medical condition, or the medical condition is non-disabling in the academic environment

SECTION 5: FUNCTIONAL LIMITATIONS IN THE ACADEMIC ENVIRONMENT

Note: Assess the functional limitations that would affect the student in post-secondary studies/the adult learning environment. Please rate the impact of the impairment using the scale below:

None: No functional limitation evident in this area.

Mild: Minimal functional limitation evident in this area. May require some degree of academic accommodations.

Moderate: Moderate degree of impairment that impact/interferes with academic functioning. Academic accommodations are likely required.

Severe: Severe degree of impairment that require accommodations. May be unable to function within the academic environment with or without accommodations.

Unknown/Cannot Assess: Unable to assess or unknown at this time

Functional Limitations

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Attention/concentration	☐	☐	☐	☐	☐	
Memory	☐	☐	☐	☐	☐	
Information processing	☐	☐	☐	☐	☐	
Managing distractions	☐	☐	☐	☐	☐	
Managing emotions	☐	☐	☐	☐	☐	
Time Management	☐	☐	☐	☐	☐	
Problem solving	☐	☐	☐	☐	☐	
Speaking	☐	☐	☐	☐	☐	
Mobility (sit, stand, walk)	☐	☐	☐	☐	☐	
Pain	☐	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	☐	
Handwriting/typing	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

Comments:
____
____
____

Impact of Functional Limitations on Academic Performance

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Learn and retain course material	☐	☐	☐	☐	☐	
Orally present information	☐	☐	☐	☐	☐	
Participate in classroom/ lab settings	☐	☐	☐	☐	☐	
Participate in timed assessments	☐	☐	☐	☐	☐	
Complete assignments (group-based)	☐	☐	☐	☐	☐	
Complete assignments (independently)	☐	☐	☐	☐	☐	
Regularly attend class/ labs	☐	☐	☐	☐	☐	
Take notes	☐	☐	☐	☐	☐	
Work with others	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

Additional information (Please provide any other information about the student's functional limitations that AccessAbility Services should consider):

SECTION 6: SUPPORT PLAN

Check the appropriate **services** and supports the student has been referred to.

- ☐ **University of Waterloo Academic Advisor:**
  - ☐ Petitions
  - ☐ Academic progression
  - ☐ Incomplete/withdraw

- ☐ **University of Waterloo Counselling and Psychological Services:**
  - ☐ Psychology for further evaluation
  - ☐ Individual treatment/group treatment
  - ☐ Workshops
  - ☐ Empower Me
  - ☐ Regular on-going support

- ☐ **University of Waterloo Health Services:**
  - ☐ Physician for further evaluation
  - ☐ Psychiatry for further evaluation
  - ☐ Nurse Practitioner (N.P.) for further evaluation
  - ☐ Case Management
  - ☐ Regular on-going support
  - ☐ Date of upcoming appointment (if known):______________________

- ☐ **Off Campus/Community Based Supports:**
  - ☐ Psychology for further evaluation
  - ☐ Physician for further evaluation
  - ☐ Psychiatry for further evaluation
  - ☐ Counselling Supports
  - ☐ Other:____
  - ☐ Date of upcoming appointment (if known):______________________

CERTIFICATE OF ATTENDING PRACTITIONER

Practitioner Name (Please print):	
Position/title:	
Organization (if external):	
Please check all that apply to you:	☐ Member of the College of Audiologists and Speech-Language Pathologists of Ontario ☐ Member of the College of Chiropractors of Ontario ☐ Member of the College of Nurses of Ontario ☐ Member of the College of Occupational Therapists of Ontario ☐ Member of the College of Physicians and Surgeons of Ontario ☐ Member of the College of Physiotherapists of Ontario ☐ Member of the College of Psychologists of Ontario ☐ Member of the College of Social Workers and Social Services Workers ☐ Member of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario ☐ First Nations, Inuit and Métis Traditional Healer/Elder ☐ Other: ______________________________
Email address:	
Phone number:	
Practitioner's signature:	
Date completed (DD/MM/YYYY):	