FUNCTIONAL LIMITATION VERIFICATION FORM

Please submit form to:
AccessAbility Services - University of Waterloo
1401 Needles Hall, 200 University Avenue West, Waterloo, ON N2L 3G1
P. 519.888.4567 ext. 35082. F. 519.746.2401
Web: uwaterloo.ca/accessability-services I E-mail: access@uwaterloo.ca

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 experiencing functional limitations in the academic environment and where a disability diagnosis has not been, or may not be, established.

(Note: If a formal diagnosis has been established, you may choose to have the disability-specific verification form 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:	
Legal name:	
Date of birth (DD/MM/YYYY):	
UWaterloo Student ID number:	
Phone number (home/cell)	
UWaterloo 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 may 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, if necessary, discuss information provided in this form.

Student's signature:	Date:

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 any functional limitations related to any of the following categories?
   - ☐ Physical disability/condition
   - ☐ Mental health disability/condition
   - ☐ Acquired brain injury (e.g., concussion)
   - ☐ Auditory/Hard of hearing disability/condition
   - ☐ Visual disability/condition
   - ☐ Other:

   ***This form is not intended for providing a learning disability diagnosis. Instead, the 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 improve beyond a baseline level of functioning
- ☐ **Permanent, episodic:** Periods of improved baseline health or functioning, interrupted by periods of greater illness, disability, or functional limitation over the course of their academic career
- ☐ **Temporary/acute:** These functional limitations are temporary, or the severity may reduce. Functional limitations should be reassessed in future. Student to be reassessed by:
- ☐ **Provisional/interim:** I am still monitoring/assessing the student. Assessment likely to be completed by:
- ☐ **No disability:** The symptoms do not constitute a functional limitation, or the functional limitation is not disabling in academic environments

SECTION 5: FUNCTIONAL LIMITATIONS IN THE ACADEMIC ENVIRONMENT

A. Functional Limitations					
Area	**NONE** No functional limitation evident in this area	**MILD** Functional limitation evident in this area	**MODERATE** Functional limitation evident in this area	**SEVERE** Functional limitation evident in this area	**UNABLE TO ASSESS OR UNKNOWN AT THIS TIME**
Attention/concentration	☐	☐	☐	☐	☐
Memory	☐	☐	☐	☐	☐
Information processing	☐	☐	☐	☐	☐
Managing distractions	☐	☐	☐	☐	☐
Managing emotions	☐	☐	☐	☐	☐
Time management	☐	☐	☐	☐	☐
Problem solving	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐
Mobility (sit, stand, walk)	☐	☐	☐	☐	☐
Pain	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐
Handwriting/typing	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

B. Impact of Functional Limitations on Academic Performance					
Area	**NONE** No functional limitation evident in this area	**MILD** Functional limitation evident in this area	**MODERATE** Functional limitation evident in this area	**SEVERE** Functional limitation evident in this area	**UNABLE TO ASSESS OR UNKNOWN AT THIS TIME**
Learn/retain material	☐	☐	☐	☐	☐
Orally present information	☐	☐	☐	☐	☐
Participate in class/lab	☐	☐	☐	☐	☐
Participate in timed assessments	☐	☐	☐	☐	☐
Complete group-based assignments	☐	☐	☐	☐	☐
Complete independent assignments	☐	☐	☐	☐	☐
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 supports the student has been referred to.

Service	Support Requested
☐ University of Waterloo Academic Advisor	☐ Petitions ☐ Academic progression ☐ Incomplete designation/withdrawal
☐ University of Waterloo Counselling & Psychological Services	☐ Psychology for further evaluation ☐ Individual treatment/group treatment ☐ Workshops ☐ Empower Me ☐ Regular ongoing support
☐ University of Waterloo Health Services	☐ Physician for further evaluation ☐ Psychiatry for further evaluation ☐ Nurse Practitioner (N.P.) for further evaluation ☐ Case Management ☐ Regular ongoing 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):

CERTIFICATION OF ATTENDING PRACTITIONER

Name of practitioner:
Position/title:
Organization (if external):

Please check all that apply to you:

- ☐ First Nations, Inuit and/or Metis Traditional Healer/Elder
- ☐ 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 Registered Psychotherapists and Registered Mental Health Therapists of Ontario
- ☐ Member of the College of Social Workers and Social Services Workers
- ☐ Other:

Email address:	Phone number:
Practitioner signature:	Date: