

FUNCTIONAL LIMITATIONS ASSESSMENT FORM

Emily Carr University of Art + Design is a specialized, accredited, public, post-secondary university that offers undergraduate, graduate degrees, and applied research in the fields of art, design and media.

Emily Carr degrees are comprised of academic and studio courses, the difference being that academic courses require more sitting, listening, note taking, reading, and writing, while the studio courses require standing and use of the body, mainly the hands in physical activity. The studio courses can involve hand and power tools, specialized equipment for work with wood, metal and plastics, as well as materials such as inks, paints, glazes, plasters and solvents.

Documentation is being requested for the purpose of establishing disability accommodations and addressing safety considerations in the Emily Carr learning environment.

PERSONAL INFORMATION – STUDENT COMPLETES THIS SECTION

Name		Date of Birth
Phone	Email	
Signature	Date	
By signing this form, you are consenting to Emily Carr University of Art + Design to receive the information requested for the purpose stated and to contact your medical assessor if additional information is required.		

ASSESSMENT - QUALIFIED MEDICAL ASSESSOR COMPLETES THIS SECTION

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

Please read the following options carefully and select ONE that best describes the student's health condition(s):

☐ This student has a **PERMANENT DISABILITY***

Permanent Disability (PD) – any impairment, including a physical, mental, intellectual, cognitive, learning, communication, or sensory impairment (or a functional limitation)—that restricts the ability of a person to perform the daily activities necessary to pursue studies at a post-secondary level or to participate in the labour force and that is expected to remain with the person for the person's expected life.

☐ This student has a **PERSISTENT OR PROLONGED DISABILITY***

Persistent or Prolonged Disability (PPD) – any impairment, including a physical, mental, intellectual, cognitive, learning, communication, or sensory impairment (or a functional limitation)—that restricts the ability of a person to perform the daily activities necessary to pursue studies at a post-secondary level or to participate in the labour force and has lasted, or is expected to last, for a period of at least 12 months but is not expected to remain with the person for the person's expected life.

Accommodations to be provided from (YY/MM/DD) _____ to ** (YY/MM/DD) _____

☐ This student is **BEING MONITORED** to determine a diagnosis

Accommodations to be provided from (YY/MM/DD) _____ to ** (YY/MM/DD) _____

OPTIONAL as per the student's discretion:

Diagnosis: _____

***PD and PPD definitions are from BC Ministry of Advanced Education and Skills Training and StudentAid BC.**

****Updated documentation will be required by the University to continue accommodations beyond this date.**

MEDICATION

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

☐ Morning
 ☐ Afternoon
 ☐ Evening
 ☐ N/A

SCALE

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

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.

1	2	3	4	5
Within normal limits	Mild or Slight	Moderate	Severe	Unknown
No functional limitation evident in this area	Functional limitation evident in this area	Functional limitation evident in this area	Functional limitation evident in this area	Unable to assess or unknown at this time

SECTION A: COGNITIVE SKILLS/ABILITIES

To be completed by: Family Physician, Medical Specialist, Psychiatrist, Psychologist, or Psychological Associate

	Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
Attention/Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short-Term Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-Term Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information Processing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Executive Functioning: planning, organizing, problem solving, sequencing, time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judgement: anticipating the impact of one's behaviour on self and others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
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Comments: Please elaborate on any of the above areas that need further explanation.

SECTION B: PHYSICAL SKILLS/ABILITIES

To be completed by: Family Physician, Medical Specialist, Psychiatrist, Psychologist, or Psychological Associate

	Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Motor/Manual Dexterity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stamina/Ability to engage in academic activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit for sustained periods of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand for sustained periods of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

SECTION C: SOCIAL-EMOTIONAL SKILLS/ABILITIES

To be completed by: Family Physician, Medical Specialist, Psychiatrist, Psychologist, or Psychological Associate

	Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
Effectively control emotions during routine academic interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effectively read social cues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effectively control emotions during evaluation situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to effectively manage the demands of academic life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participate appropriately during in-class and group work situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to respond to change effectively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Please elaborate on any of the above areas that need further explanation.					

SECTION D: VISION

Visual acuity loss (best corrected), left eye, right eye, bilateral, visual field limitations

To be completed by: Family Physician, Optometrist or Ophthalmologist

	Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
Comments, if needed:					

SECTION E: HEARING

Hearing loss (best corrected), left ear, right ear, bilateral

To be completed by: Family Physician, Audiologist

	Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments, if needed:					

SECTION F: SPEECH

To be completed by: Speech-Language Pathologist or Family Physician

	Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments, if needed:					

SECTION G: SAFETY

To be completed by: Family Physician or Medical Specialist

Does this student have a condition such that the 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, including triggers, presentation, frequency of occurrence, severity, duration and suggested response:

Is there anything else you think we should know about this student's disability: ambulation, standing, sitting, lifting, carrying, reaching, grasping, exerting or whether there are safety considerations in the operation of hand and/or power tools?

If yes, please describe condition:

SECTION H: SPECIALIZED EQUIPMENT AND SERVICES

To be completed by any of the aforementioned professionals.

Based on the functional limitations you identified above, is there a need for specialized equipment and/or services?

☐ Yes ☐ No

If the answer is yes, please check items required AND provide a rationale as to why the specialized equipment or service is needed.

Specialized Services

<input type="checkbox"/> Sign Language Interpretation	<input type="checkbox"/> Transcriber	<input type="checkbox"/> Alternate Format Materials	<input type="checkbox"/> Note-taker
<input type="checkbox"/> Other, please specify:			

Specialized Equipment

<input type="checkbox"/> Ergonomic furniture	<input type="checkbox"/> Specialized Lighting
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Assistive Technologies

<input type="checkbox"/> Use of a screen reader	<input type="checkbox"/> Voice to text software	<input type="checkbox"/> Magnification Equipment
<input type="checkbox"/> Laptop	<input type="checkbox"/> Text to Voice Software	<input type="checkbox"/> Amplification System
<input type="checkbox"/> Video captioning	<input type="checkbox"/> Other, please specify:	

Rationale for Specialized Services/Equipment:

SECTION D: INTERNSHIPS/CO-OP WORK PLACEMENTS – SPECIFIC SKILLS/ABILITIES

To be completed by: Family Physician, Medical Specialist, Psychiatrist, Psychologist, or Psychological Associate

Complete only when an internship/co-op placement is part of the student's program of study

	Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
Work safely with vulnerable populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stamina: meet the demands of fieldwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

CERTIFICATE OF APPROVED PROFESSIONAL

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

License Number/Registration Number: _____

I, _____, am a legally qualified _____

in the province of _____ and this report contains my clinical assessment and considered opinion at this time.

Signature: _____ Date: (YY/MM/DD): _____

Stamp or Business Card: