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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 TO BE COMPLETED BY QUALIFIED MEDICAL ASSESSOR

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.

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 (YY/MM/DD) _____ to** (YY/MM/DD) _____

3. This student is **BEING MONITORED** to determine a diagnosis

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

4. What is the diagnosis? This is optional as per the student's discretion. _____

***Updated documentation will be required by the University after 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 No functional limitation evident in this area	**Mild or Slight** 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

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	☐	☐	☐	☐	☐
Short-Term Memory	☐	☐	☐	☐	☐
Long-Term Memory	☐	☐	☐	☐	☐
Information Processing	☐	☐	☐	☐	☐
Manage Distractions	☐	☐	☐	☐	☐
Executive Functioning: planning, organizing, problem solving, sequencing, time management	☐	☐	☐	☐	☐
Judgement: anticipating the impact of one's behaviour on self and others	☐	☐	☐	☐	☐
Communication	☐	☐	☐	☐	☐
Other (please describe)	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐
Gross Motor	☐	☐	☐	☐	☐
Fine Motor/Manual Dexterity	☐	☐	☐	☐	☐
Stamina/Ability to engage in academic activities	☐	☐	☐	☐	☐
Sit for sustained periods of time	☐	☐	☐	☐	☐

	Normal 1	Mild 2	Moderate 3	Severe 4	Unknown 5
Stand for sustained periods of time	☐	☐	☐	☐	☐
Other (please describe)	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐
Effectively read social cues	☐	☐	☐	☐	☐
Effectively control emotions during evaluation situations	☐	☐	☐	☐	☐
Ability to effectively manage the demands of academic life	☐	☐	☐	☐	☐
Participate appropriately during in-class and group work situations	☐	☐	☐	☐	☐
Ability to respond to change effectively	☐	☐	☐	☐	☐
Other (please describe)	☐	☐	☐	☐	☐
Comments: Please elaborate on any of the above areas that need further explanation.					

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

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

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

	Normal 1	**Mild 2**	**Moderate 3**	**Severe 4**	**Unknown 5**
Work safely with vulnerable populations	☐	☐	☐	☐	☐
Stamina: meet the demands of fieldwork	☐	☐	☐	☐	☐
Other (please describe)	☐	☐	☐	☐	☐
Comments: Please elaborate on any of the above areas that need further explanation.					

SECTION E: 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	☐	☐	☐	☐	☐
Other (please describe)	☐	☐	☐	☐	☐
Comments, if needed:					

SECTION F: 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	☐	☐	☐	☐	☐
Other (please describe)	☐	☐	☐	☐	☐
Comments, if needed:					

SECTION G: SPEECH

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

	Normal 1	**Mild 2**	**Moderate 3**	**Severe 4**	**Unknown 5**
Speech	☐	☐	☐	☐	☐
Other (please describe)	☐	☐	☐	☐	☐
Comments, if needed:					

SECTION H: 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 I: 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

☐ Sign Language Interpretation	☐ Transcriber	☐ Alternate Format Materials	☐ Note-taker
☐ Other, please specify:			

Specialized Equipment

☐ Ergonomic furniture	☐ Specialized Lighting

Assistive Technologies

☐ Use of a screen reader	☐ Voice to text software	☐ Magnification Equipment
☐ Laptop	☐ Text to Voice Software	☐ Amplification System
☐ Video captioning	☐ Other, please specify:	

Rationale for Specialized Services/Equipment:

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 British Columbia and this report contains my clinical assessment and considered opinion at this time.

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

Stamp or Business Card: