Functional Assessment Form

CONFIDENTIAL

The information on this form is used to determine appropriate academic accommodations at Yorkville University and Toronto Film School in accordance with the applicable human rights laws. The use and disclosure of all information is subject to all applicable privacy legislation.

Student Section	
Last Name:	First Name:
Student's Date of Birth:	Student ID:

Student Consent for Release of Information (Write initials to provide consent)

☐ I hereby authorize my regulated healthcare professional (RHCP) to provide the information in this form to Accessibility and Academic Accommodations at Yorkville University and Toronto Film School and, if required, to supply additional information related to my disability-related services. I also authorize the Accessibility and Academic Accommodations Office to contact the RHCP to discuss the provision of academic accommodations.

☐ I hereby authorize my RHCP to disclose my diagnosis to Accessibility and Academic Accommodations at Yorkville University and Toronto Film School. Please note **that students are not required to disclose their disability** diagnosis to receive academic accommodation. However, it is recognized that Accessibility Offices have expertise in supporting students with disabilities, and disclosing information can promote the planning and implementation of individual accommodation plans.

Important Notes for Students

1. The form must be completed by a regulated healthcare professional who is qualified to diagnose in the relevant field impacting the student.
2. The form gathers the functional impact of the student's disability to determine appropriate accommodations. In some cases, additional information may need to be provided to support accommodation planning.
3. Psychoeducational assessments for learning disabilities are used to support accommodation planning.
4. Interim accommodation may be provided for those who are gathering documentation to support an accommodation determination.

How to submit the Functional Assessment Form

There are several ways to submit the Functional Assessment Form to the Accessibility and Academic Accommodations Office at Yorkville University and Toronto Film School

1. Students can upload the completed form to the Student Intake Form
2. Students or medical offices can email the form to accessibility@yorkvilleu.ca or fax 647 943-4967

Regulated Healthcare Professional Section

To complete this section of the form, **you MUST be a Healthcare Professional under the jurisdiction of the appropriate provincial or territorial Healthcare Professions legislation,** who, has the right to determine the controlled act of diagnosis. As such, the form must only be completed by those **regulated healthcare professionals whose scope of practice includes the act of diagnosing within the relevant areas impacting the student.** Professionals are asked to complete only those sections below that relate to their scope of practice as thoroughly as possible based on the evaluation of the student's needs and the areas impacting academic participation.

Assessment Information

This student has been my patient for: ☐ More than 2 years ☐ Less than 2 years ☐ Walk-in/1st Visit

I confirm that the student experiences functional impact from a health condition/disability that causes barriers for them to participate academically at Yorkville University and Toronto School, and these barriers are:

- ☐ Permanent and expected to remain with the student for their lifetime with symptoms that are continuous ☐ OR recurrent/ episodic ☐
- ☐ Persistent and prolonged, and expected to remain with the student for at least 12 months with symptoms that are continuous ☐ OR recurrent/ episodic ☐
- ☐ Temporary and/or being monitored with symptoms that are continuous ☐ OR recurrent/episodic ☐

Accommodations to be provided from ____________ to *(including date of next assessment)* ____________

Updated documentation will be required after the expiry of ongoing accommodations.

Diagnosis (if student consented):

Functional and Learning Assessment

Assessment of Skills and Abilities

Using the scale, please indicate the functional impact of the health condition/disability and/or medication side effects. Complete <u>only</u> the appropriate sections related to your scope of practice.

COGNITION and/or BEHAVIOURAL *(only to be completed by a Family Physician, Psychologist, Psyc. Associate, Psychiatrist or Medical Specialist, as per one's scope of practice)*

Skill/Ability	No impact or unable to assess	Mild or slight Impact	Moderate Impact	Severe Impact	**Comments**
Attention/Concentration					
Short-Term Memory					
Long-Term Memory					
Managing Distractions					
Planning					
Organizing					
Cognitive Flexibility and Problem-Solving					

Skill/Ability	No Impact or unable to assess	Mild or slight Impact	Moderate Impact	Severe Impact	**Comments**
Sequencing					
Time Management					
Information Processing					
Judgment: anticipating the impact of one's behaviour on self and others					
Verbal Communication					
Written Communication					
Stress management					
Emotional self-regulation during academic interactions					
Emotional self-regulation during evaluation situations					
Social interactions					
Public speaking					
Other (please specify)					
PHYSICAL *(only to be completed by a Family Physician, or Medical Specialist as per one's scope of practice)*					
Mobility					
Gripping/grasping/dexterity					
Stamina/Ability to engage in academic activities e.g., take a full course load, complete a 35hr work week					
Attend live in-person classes					
Sit for sustained periods					
Stand for sustained periods					
Fatigue					
Sensitivity to Light					
Nausea					
Other (please specify)					
SENSORY *(only to be completed by a/an Family Physician, Audiologist, Optometrist, Ophthalmologist, or Speech-Language Pathologist, as per one's scope of practice)*					
Vision (best corrected)					
Hearing (best corrected)					
Speech					

Other (please specify)					

Additional Comments and/or Accommodation Recommendations (please note while recommendations will be considered, they cannot be guaranteed given the academic requirements of the program and/or the student's functional impact. Alternatives may be offered if suitable)

Safety

Does this student have a condition such that the college/university may need to respond in an emergency if symptoms of the condition appear while the student is on campus? (e.g., seizure disorder, anaphylaxis, etc.)

Yes ☐ No ☐

If yes, please provide more information relating to the emergency:

Type of emergency: ☐Seizures ☐ Anaphylaxis ☐Other (please specify): ________________

Frequency of emergency: ☐Continuous (Daily, weekly, monthly) ☐Recurrent/Episodic

Signs and Symptoms: ____

Impact on academic functioning: ____

Note: Students will receive standard first aid response should medical attention be required.

Medication

Is the student prescribed medication(s) that would negatively affect student academic functioning?

☐Yes ☐No

Impact of medication on academic functioning: ☐Mild ☐Moderate ☐Severe

If there is an impact of medication on the student's academic functioning, when is it likely? (check all that apply)

☐ Morning ☐Afternoon ☐ Evening

Note: Students must be able to administer or take medication on their own

Regulated Healthcare Professional Certification

Name of Health Care Practitioner:

License/Registration No: ___________________________________

Address: ____

City: _______________ Province: _______ Postal code: __________

Phone: _______________________ Fax: ______________________

Official stamp

Signature:

Date Completed: