Services for Students with Disabilities
Verification Form for Students with Blindness and Low Vision

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the “Guidelines for Documenting Blindness or Low Vision” for comprehensive documentation requirements and additional information. The acceptable age of the documentation is dependent upon the nature of the condition. In cases where the condition is permanent or unchanging SSD may require current functional limitation from a qualified provider. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation. All information will be kept confidential. Please feel free to contact SSD at (512) 471-6259 with questions.

The information below is to be completed and signed by the student.

I request and authorize The University of Texas at Austin University Health Services (UHS), Counseling & Mental Health Center (CMHC), Services for Students with Disabilities and/or my off-campus provider (name)____________________ to release, fax, mail or discuss with each other information related to my registering with Services for Students with Disabilities (SSD).

Student Name                                                                                                  EID
____________________________________  ______________________

Student Signature                                                             Date

Email Address: ___________________________________  Phone Number: _______________________

If the information above is left blank or is incomplete it may delay or prevent SSD from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.
The information below is to be completed and signed by the Provider.

1. **Diagnosis:** Please list all diagnoses and supporting numerical assessments of vision.

   __________________________________________________________________________
   __________________________________________________________________________

   *Visual Acuity with correction: ________________________________
   *Visual Acuity without correction: ________________________________

   a. Approximate onset of diagnosis

   o Child-approximate age: __________________________
   o Adolescent-approximate age: _________________________
   o Adult-approximate age: _____________________________
   o Unknown

   b. Date of your last clinical contact with student: _______ / _______ / _______

2. **Evaluation**

   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

      o Medical evaluation (x-ray, lab work, EKG, etc.).
      o Standard eye exam.
      o Specialized eye exam: Specify__________________________
      o Structured or unstructured interview with student.
      o Interviews with other persons (i.e. parent, teacher, therapist)
      o Behavioral observations.
      o Other (Please specify).

   b. **Evaluation Results**

      __________________________________________________________________________
      __________________________________________________________________________
      __________________________________________________________________________

   c. Present symptoms that meet criteria for diagnosis being noted.

      __________________________________________________________________________
      __________________________________________________________________________
d. Current treatment being received by student:
   - Medication management
     - Current medications: ________________________________
     - Other (please describe): ________________________________

e. Severity of symptoms
   - Mild
   - Moderate
   - Severe

f. Prognosis of disorder:
   - good (vision loss is stable)
   - fair (vision loss is changing but individual retains functional level of sight)
   - poor (vision is degenerative)

3. Functional Limitations

   a. Does this condition significantly **limit one or more of the following major life activities**?

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<thead>
<tr>
<th>Activity</th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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<tbody>
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<td>Communicating</td>
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<td>Concentrating</td>
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<td>Hearing</td>
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<td>Learning</td>
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<td>Manual Tasks</td>
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<td>Reading</td>
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<td>Other:</td>
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</table>
b. Please check the **functional limitations or behavioral manifestations** for this student:

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<th>Not an Issue</th>
<th>Moderate Issue</th>
<th>Substantial Issue</th>
<th>Don't Know</th>
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<td>Cognitive Processing</td>
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<td>Memory</td>
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<td>Processing Speed</td>
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<td>Meeting Deadlines</td>
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<td>Attending class</td>
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<td>Organization</td>
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<td>Reasoning</td>
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<td>Stress</td>
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<td>Appetite</td>
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c. Please describe in detail any functional limitations that fall into the substantial range.

__________________________________________________________________________

__________________________________________________________________________

d. Special considerations, e.g. medication side effects: __________________________

__________________________________________________________________________

__________________________________________________________________________

4. **Accommodations**

a. Please mark whether student has utilized accommodations in the past.

  - o Yes Please describe: ______________________________________________________

  - o No

  - o Don't Know
b. (Optional) Recommended educational accommodations:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information on the next page. This form should be signed and returned via fax or mail to the SSD office at the address shown at the end of this document.

All documentation submitted to SSD is considered confidential.

**Provider Information**

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: ___________________________ Date: ___________________________

Print Name and Title: ___________________________

State of License: ______________ License Number: ___________________________

Address

Street or P.O. Box ___________________________ City ___________________________ State ___________________________ Zip ___________________________

Phone: ___________________________ Fax: ___________________________

Please return this form to:
The University of Texas at Austin
Division of Diversity and Community Engagement
Services for Students with Disabilities
100 W. Dean Keeton St. Stop A4100
Austin, TX 78712-1093
Phone: (512) 471-6259
Fax: (512) 475-7730
VP: (512) 410-6644

Attach Provider Business Card Here