Disability and Access
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 D&A 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), Disability and Access and/or my off-campus provider (name)______________________ to release, fax, mail or discuss with each other information related to my registering with Disability and Access (D&A).

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 D&A 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

- Child-approximate age:____________________
- Adolescent-approximate age:____________________
- Adult-approximate age:____________________
- 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.

- Medical evaluation (x-ray, lab work, EKG, etc.).
- Standard eye exam.
- Specialized eye exam: Specify___________________________________
- Structured or unstructured interview with student.
- Interviews with other persons (i.e. parent, teacher, therapist)
- Behavioral observations.
- 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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<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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<td>Manual Tasks</td>
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<td>Other:</td>
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b. Please check the **functional limitations or behavioral manifestations** for this student:

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<th>Substantial Issue</th>
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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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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.
   - Yes  Please describe: ______________________________________________________
   - No
   - 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 D&A office at the address shown at the end of this document.

All documentation submitted to D&A 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
Disability and Access
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