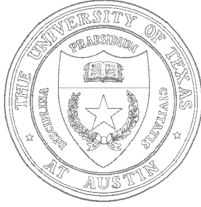

DIVISION OF DIVERSITY AND COMMUNITY ENGAGEMENT
THE UNIVERSITY OF TEXAS AT AUSTIN

Services for Students with Disabilities •1 University Station A4100 • Austin, TX 78712-0175
http://www.utexas.edu/diversity/ddce/ssd/
(512) 471-6259 • FAX (512) 475-7730 • VP (866) 329-3986

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 a Vision Loss" 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. ***This form is to be completed and signed by PROVIDER.***

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

____
Student Signature Date

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:

- o Medication management

  Current medications: ____

- o Other (please describe): ____

e. Severity of symptoms

- o Mild
- o Moderate
- o Severe

f. Prognosis of disorder:

- o good (vision loss is stable)
- o fair (vision loss is changing but individual retains functional level of sight)
- o poor (vision is degenerative)

3. Functional Limitations

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

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

b. Please check the **functional limitations or behavioral manifestations** for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don't Know
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				
Other:				

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
1 University Station A4100
Austin, TX 78712-0175
Phone: (512) 471-6259
Fax: (512) 475-7730
VP: (866) 329-3986

Attach Provider Business Card Here