DIVISION OF CAMPUS AND COMMUNITY ENGAGEMENT

THE UNIVERSITY OF TEXAS AT AUSTIN

Disability and Access · 100 West Dean Keeton St. A4100 · Austin, TX 78712-1093
community.utexas.edu/disability/ · (512) 471-6259 · FAX (512) 475-7730 · VP (512) 410-6644

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 D&A 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**?

	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 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 Campus and Community Engagement
Disability and Access
100 W. Dean Keeton St. Stop A4100
Austin, TX 78712-1093
Phone: (512) 471-6259
Email: access@austin.utexas.edu
Fax: (512) 475-7730
VP: (512) 410-6644

Attach Provider Business Card Here