Visual Impairment Documentation Form

Student Name: ___________________________ DOB: ______/____/____ has requested disability support services from the Office of Disability Services for Students (DSS) at Indiana University Bloomington (IUB) in regard to a visual impairment. Documentation provides vital information about the functional limitation of the student’s disability and its impact in a post-secondary academic environment.

Please complete all sections of this form and return it as soon as possible so that we may verify the student’s eligibility for services. Providers may also use their own documentation format as long as all of the information requested below is included; if this information is not provided, services may be delayed as DSS obtains clarification. Please call 812-855-7578 if you have questions. The completed form may be faxed to 812-855-7650 or it may be mailed to the address at the bottom of this page. DSS welcomes any additional documentation you would like to include.

Diagnoses
Primary: __________________________________________

Secondary: __________________________________________

Date of Diagnosis: ______/____/____ Last appointment: ______/____/____

What is the student’s current best corrected visual acuity and visual field in each eye?

<table>
<thead>
<tr>
<th>Visual Acuity</th>
<th>Visual Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Near</td>
<td>Central Peripheral</td>
</tr>
</tbody>
</table>

Characteristics of vision loss: □ Stable □ Declining □ Slow Progression □ Rapid Progression

Recommended time-frame for update: ________________________________

Please describe the proficiency of orientation and mobility of the student for independent travel.

□ Has usable vision □ Proficient in cane usage □ Uses a service dog
□ Uses GPS technology or other technologies □ needs additional orientation and mobility training

Please provide further information, if needed: ______________________________________________________
____________________________________________________________________________________________

What does the student use to access print?

□ Enlarged Print: Font Size ________ □ Braille □ Text reader □ Screen reader
□ Other ________________________________________________
Does the student have a color deficiency that would impact achievement in the academic setting? (i.e. Lab)
If so, please specify the type of deficiency, severity and visual aids that would be beneficial.

Red- Green Color Blindness: ______________________________________________________
Blue- Yellow Color Blindness: ____________________________________________________
Complete Color Blindness: _______________________________________________________

Additional comments and recommended auxiliary support, strategies, or service that may be beneficial to the student in the higher education environment.

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Certifying Professional

Name (print): ____________________________________________ Date: ____/____/_____ 
Profession: __________________ License number: ____________
Office Address: ____________________________________________
Phone: ______________ Fax: ______________ Email Address: ______________

Certifying Professional Signature: ________________________________