Blind/Low Vision: Accommodation Support Form

NOTE: ***Please type or print your answers on this form.***

Student Information

Student Name:______________________________
Student ID Number:______________________________
Campus Address:______________________________
Local Phone Number:______________________________
Date of Birth:______________________________
Date of Evaluation:______________________________

Cause of Vision Loss

- ☐ Retinal degeneration
- ☐ Cataracts
- ☐ Muscular problem
- ☐ Diabetic retinopathy
- ☐ Infection
- ☐ Trauma
- ☐ Albinism
- ☐ Glaucoma
- ☐ Corneal disorder
- ☐ Congenital disorder
- ☐ Cortical
- ☐ Other Please list.__________________

Please give brief explanation of cause.______________________________

Severity of Loss

Severity of Loss	Eye Affected		
☐ No vision loss	☐ R	☐ L	☐ R&L
☐ Mild	☐ R	☐ L	☐ R&L
☐ Moderate	☐ R	☐ L	☐ R&L
☐ Severe	☐ R	☐ L	☐ R&L
☐ Total	☐ R	☐ L	☐ R&L

Age of Onset

Age of onset__________________ Date of onset_______________________

Visual Fields

Please describe the extent of visual fields.

Visual Acuity

Please describe the degree of visual acuity.

Current Impact of Vision Loss on Academic Functioning

Please describe the effects of the vision loss on academic functioning.

Prognosis

Please describe the prognosis.

Prescribed Treatment

Please list prescribed treatments, care, assistive devices, etc. and any effects the treatment may have on functioning.____

Recommendations for Accommodations/Referrals

- ☐ Audio format of written course materials
- ☐ Braille format of written course material
- ☐ Extended time for exams (time and a half)
- ☐ Extended time for exams (double time)
- ☐ Scribe for scantron exam forms
- ☐ Scribe for essay exams
- ☐ Computer to type answers to exam questions
- ☐ Orientation and mobility training to unfamiliar environments
- ☐ Housing accommodations. Please list.______________________________
- ☐ Lab assistant
- ☐ Service animal
- ☐ Reader for exams
- ☐ Braille exams
- ☐ Audio format of exams
- ☐ Enlarged Exams
  - Font size

- ☐ Referral for further assessment. Please indicate all that apply
  - ☐ Alcohol and drug
  - ☐ Anxiety
  - ☐ Depression
  - ☐ Other. Please list.________________

Evaluator Information

Evaluator Name:______________________________
Evaluator Title:______________________________
Evaluator Signature:______________________________
Address:______________________________
Phone Number:______________________________
Fax Number:______________________________
Email Address:______________________________