VISUAL VERIFICATION FORM

The diagnosing professional must be a physician or other medical specialist with experience and expertise in the area related to the student's disability. Form can be handwritten but please be clear and neat.

Student Name: _____

Student Number: _____

SECTION I **MEDICAL EXAMINATION**

Visual Acuity Snellen notations (20 feet for distance; 16 inches for reading):

Distance	Without glasses:		With best correction:		Percentage loss with correction:		
	R	L	R	L	R %	L %	
Reading	Without glasses:		With best correction:		Percentage loss with correction:		
	R	L	R	L	R %	L %	
Refraction Record	Sphere:		Cylinder:		Axis:		
	R	L	R	L	R	L	

Is the difference in spherical correction of the two eyes more than 3 diopters? Yes ☐ No ☐

Visual Field: (If restricted or if scotomata are presented describe in pathology)	Normal: _____	Restricted: _____	Method used: _____
Muscle Function: (If restricted describe under pathology)	Normal: _____	Restricted: _____	
Binocular Function:	Does patient have useful binocular vision in all direction? Yes ☐ No ☐ Distance: _____ Near: _____ Depth: _____		

Color Perception: Normal ☐ Not Normal ☐ Color blind: which colors? _____

Method Utilized: _____

_____

Intra-ocular tensions: Within expected parameters _____

Not within expected parameters _____

Please briefly comment on this patient's ambulation skills and capabilities: _____

SECTION II **DIAGNOSIS**

Eye Pathology	Primary Condition: _____
	Secondary Condition: _____

Primary and contributory causes of condition: _____

Characteristics of condition: Stable ☐ Progressive ☐ Improving ☐ Recurrent ☐ Permanent ☐

Accommodative skills: (at near point, with and without lenses) _____

Oculomotor skills: [saccades, pursuits, tracking (rate nystagmus)]

SECTION III PROGNOSIS AND RECOMMENDATIONS

Prognosis of the condition:

Treatment recommended:
(medical or other therapies)

Functional limitations: Yes ☐ No ☐ Describe if yes:

Coexisting conditions: (provide details about any coexisting medical or psychiatric conditions, please include relevant reports)

Past accommodations: Yes ☐ No ☐ (please describe if yes)

Suggested accommodations: (please list specific academic accommodations you suggest based on your assessment of student clinical and academic history and diagnosis)

Technology (was the student given an assistive technology evaluation?) Yes ☐ No ☐ If so, please attach report

What technology has been utilized in the past?

Please list any technology related accommodations

Provide a detailed description of (1) how the individual's condition/impairment affects his or her reading ability and (2) why each recommended accommodation is needed. Your recommendation should not be supported solely by a history of prior accommodation. You can prepare a narrative in a separate sheet of paper.

Examiner's Name and Title

Signature

License/Certification Number

Date