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

Visual Field:
(If restricted or if scotomata are presented describe in pathology)

Muscle Function:
(If restricted describe under pathology)

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 _______