



Visual Impairment Documentation Form

Student Name: _____ **DOB:** ____/____/____ has requested support services from Accessible Educational Services (AES) at Indiana University Bloomington (IUB) regarding a visual impairment. Documentation provides vital information about the functional limitation of the student’s qualifying medical condition 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 if all of the information requested below is included; if this information is not provided, services may be delayed as AES 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. AES 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?

Visual Acuity		Visual Field	
Distance	Near	Central	Peripheral

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 _____



OFFICE OF STUDENT LIFE

ACCESSIBLE EDUCATIONAL SERVICES

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: _____