

Requirements for Reports Documenting Vision Impairments

Western Illinois University's office of Disability Support Services (DSS) facilitates accommodations and services for qualified students with disabilities enrolled at Western. Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) protects students from discrimination on the basis of disability and ensures the provision of reasonable accommodations. The following documentation guidelines establish that a student is eligible for accommodations and services under these laws, demonstrate that the disability produces a significant, functional impact on a major life activity, and support the student's request for accommodations. **All professional reports or letters should be type-written on professional letterhead, dated and signed.**

A. Qualified Evaluator

Professionals conducting evaluations and rendering diagnoses of vision impairments must be a certified practicing medical doctor (MD) or optometrist (OD) and must hold qualifications that are recognized by the state of Illinois as affirming his or her eligibility to diagnose vision impairments.

B. Current Documentation

DSS professionals must be able to ascertain the current impact of the condition in order to determine appropriate accommodations. Therefore, the documentation should be up-to-date and address current functional limitations.

C. Diagnosis and Impact

A comprehensive report should include the following information:

- Type and severity of vision loss, date of onset, and subsequent progress and treatment of the condition
- Extent of visual fields and degree of visual acuity
- Effects of the vision loss on general and academic functioning
- Currently prescribed or recommended treatment, care or assistive devices
- Types of activity that are specifically contraindicated by the student's condition

D. Need for Accommodations

The report should describe the current and significant functional limitations that warrant accommodations and provide recommendations for academic accommodations that are directly linked to those limitations. In addition, recommendations for accommodations pertaining to campus board, room, or transportation needs should be included.

Professional Evaluator's Documentation Checklist: Vision

Student Information

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

Cause of Vision Loss

_____ Retinal degeneration	_____ Albinism
_____ Cataracts	_____ Glaucoma
_____ Muscular problem	_____ Corneal disorder
_____ Diabetic retinopathy	_____ Congenital disorder
_____ Infection	_____ Cortical
_____ Trauma	_____ 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

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

Referral for further assessment. Please indicate all that apply

<input type="checkbox"/> Alcohol and drug	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other. Please list. _____

Evaluator Information

Evaluator Name: _____

Evaluator Title: _____

Evaluator Signature: _____

Address: _____

Phone Number: _____

Fax Number: _____

Email Address: _____