# DOCUMENTATION OF VISUAL IMPAIRMENT

## PART 1. STUDENT INFORMATION

Student Name: ____________________________________________________________

Date of Birth: __/__/____  Student #: _________________________________________

Month  Day  Year

## PART 2. DOCUMENTATION OF DISABILITY

A. To be completed by the registered Psychiatrist, Psychologist, or a treating Family Physician. At the discretion of SAS, documentation from a General Practitioner is accepted for the purpose of establishing temporary/interim disability services and accommodations, especially if a diagnosis is being explored or assessed. All sections of the form must be completed carefully and objectively to ensure accurate assessment of the student’s disability-related needs.

B. Careful consideration should be given to the statement of disability and degree of impairment.

Disability is defined as a functional limitation or impairment that is related to a student’s ability to perform the daily activities necessary to participate in post-secondary studies. The degree of disability can range from mild to moderate, severe, or profound.

Does this student have a disability according to the above definition?

☐ Yes  ☐ No

### Statement of Disability (Prognosis):

Please select ONE of the following statements that apply to the student in the current academic setting:

- [ ] Permanent – Chronic (ongoing symptoms for the duration of natural life)
- [ ] Permanent – Acute (recurring episodes with relatively symptom free period of remission)
- [ ] Temporary – Chronic (ongoing symptoms)
- [ ] Temporary – Acute (episodic symptoms)

The following criteria must be met for determination of permanent disability:

- Functional limitation due to a medical condition
- Functional limitation that restricts ability to perform daily activities necessary to participate in post-secondary studies
- Functional limitation that is expected to be life long

For OSAP purposes, a permanent disability is defined as a functional limitation caused by a physical or mental impairment that restricts a student’s ability to perform the daily activities necessary to participate in studies at the postsecondary level or labour force. It is expected that the condition will remain with them and need to be managed over the course of their life.

It is anticipated that the student will experience functional limitations affecting their ability to participate in postsecondary studies with duration from __/____ to __/____

Month  Year  Month  Year

(or ☐ unknown duration)

OR Disability status must be reassessed every _____ (months or years) due to the episodic nature of illness.
DETAILED EVALUATION

1. Specific Diagnosis: ____________________________________________________________

2. Age of Diagnosis: _____________________________________________________________

3. Cause of impairment: __________________________________________________________

4. Visual Acuity Loss (best corrected) _______ Left Eye _______ Right Eye _______ Bilateral

5. Visual Field Limitations: _______________________________________________________

Degree of Impairment is: ☐ Mild ☐ Moderate ☐ Severe/Profound

6. Is this student a regular patient of yours? ☐ Yes ☐ No

7. While this student is enrolled at the University, will you be monitoring him/her on a regular basis?
   _______ Yes, every: _____________________________________________________________
   _______ No, this student will be followed by:_______________________________________

8. Is this student currently taking medication(s) ☐ Yes ☐ No
   If yes, please list the student’s current medications and how they may impact on their activities of daily living, particularly academic performance (e.g. time of day, alertness, concentration, fatigue etc.)
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

9. Describe the functional limitations (e.g. mobility, coordination, etc.) associated with this impairment, and how they impact on activities of daily living including academic life and work.
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

10. Does the student require specialized devices (e.g. glasses) and/or equipment in order to participate in postsecondary education? Please specify:
    ____________________________________________________________________________
    ____________________________________________________________________________
    ____________________________________________________________________________
    ____________________________________________________________________________

11. What specific academic accommodations do you recommend?
    ____________________________________________________________________________
    ____________________________________________________________________________
    ____________________________________________________________________________
    ____________________________________________________________________________
12. Please provide additional information that may assist us in determining appropriate disability services.

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

PLEASE PROVIDE THE MOST RECENT AUDIOGRAM CONDUCTED

CERTIFICATE OF ATTENDING PROFESSIONAL
*Please affix a business card if your office does not have a stamp*

Name: ___________________________________________________ Address / Office Stamp / Business Card
Signature: ____________________________________________________________________________
Designation: __________________________________________________________________________
Area of Expertise: __________________________________________________________________________
Registration #: __________________________________________________________________________
Date: ____________________________________________________________________________________
Telephone: ________________________________________________________________________________
Fax: ____________________________________________________________________________________

PART 3. STUDENT’S WRITTEN AND INFORMED CONSENT AND RELEASE TO SHARE INFORMATION

I ___________________________________________________ (student name) authorize and give consent for the information
regarding my disability provided on this form be released to authorized persons within the UOIT Student Accessibility
Services office for the purpose of establishing or reviewing academic accommodations.

I give consent for authorized persons within Student Accessibility Services to contact the health professional listed
on this form to discuss the information regarding my disability and accommodation needs outlined on this form.

Student Signature: ___________________________ Date: ___________________________