REQUEST FOR VISUAL IMPAIRMENTS DOCUMENTATION

Verification of a disability may make this student eligible to receive services, bursaries and accommodations. Therefore, your careful and objective assessment of this student's eligibility is required. If the student signs a release form, the student's Paul Menton Centre coordinator may contact you for further information.

Patient Name: ________________________________

Date of Birth: (Year/Month/Day) _______ / _______ / _______

Is this person a regular patient of yours/your clinic?______ Yes ______ No

If YES, how frequent has this patient been treated in the past 2 years? ________________________________

____________________________________________

Specific diagnosis: _____________________________ Age of diagnosis: ___________

Cause of impairment: ______________________________________________

Visual acuity (best corrected) _______ Left eye _______ Right eye _______ Bilateral

Visual field limitations: ______________________________________________

Please check one of the following statements:

_____ Not a disability

_____ Temporary or recurring visual impairment that may affect academic functioning and require special consideration for a short duration. The anticipated duration you expect this patient to be affected by his/her visual impairment is from _____ / ____ / ___ to _____ / ____ / ___ (Year/Month/Day).

_____ Permanent/on-going disability that will require PMC assistance for duration of university.

Do you consider the visual impairment:_____mild______moderate______severe

____________________________________________
Describe the functional limitations associated with this impairment, and how they impact on activities of daily living including academics.

List the patient’s current medications and how they may impact on their activities of daily living, particularly academic performance (e.g. time of day, alertness, fatigue etc.)

Does the patient require specialized devices (e.g. glasses) and/or assistive technology in order to participate in post-secondary education? Please specify.

Do you consider your patient to be in stable condition and capable of sustaining normal academic stress?

_____________ Yes   No_______ Not sure_____

While this patient is enrolled at the University, will you be monitoring him/her on a regular basis?

______Yes______No     If YES, how often? ______________________________

If there any further information you could provide that would aid us in providing assistance to this student?

________________________________________

Certificate of Attending Registered / Certified Health Professional

Area of Expertise:

___ Ophthalmologist ________________ Optometrist ________________ Low Vision Specialist

___ Family Physician who is familiar with the patient’s medical history

___ Other (specify): _____________________________________________________________

Physician Registration #: ______________________

Name: ___________________________________________ Telephone: _____________________________

Address: __________________________________________________________________________

Signature: _______________________________ Date: ________________________________