Disclosure Form – Vision Impairment
Information for clinicians

You are receiving the attached Disability Disclosure Form – Vision Impairment - because a student under your care is requesting accommodations from the Disability Resource Center (DRC) at Northeastern University.

A diagnosis of a vision impairment does not, in and of itself, qualify a student for accommodations under the ADAAA. Accommodations are not based on the student's diagnosis, but instead are designed to address the barrier(s) caused by any substantial limitation(s) related to the disorder. Accommodations are meant to allow full participation in academic and university life for students with disabilities; they do not guarantee student success. The DRC uses a multi-source process to determine eligibility for disability-related accommodations, which includes self-report, history of accommodations (when available), and clinical observations. This form is intended to provide us with the latter.

Please note that the information you provide in response to the questions on this form must be current; in general, you must have seen the student within the last 6 months to meet this requirement. If you have recently begun treating this student, you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly.

If you have questions or concerns about this form, how the information is used, or how best to support the student, we invite you to contact our office, at 617.373.2675 or email DRCDocumentation@northeastern.edu.

Disability Disclosure Form – Vision Impairment

Dear (Clinician Name)____

I am requesting services from the Disability Resource Center (DRC) at Northeastern University. In order to receive services, the DRC requires documentation of my disability. Services at the DRC are solely based on diagnostic documentation. Once this information is in place, it will be used to develop a service plan for me.

☐ I hereby authorize you to complete the enclosed Disclosure Form and release it to the DRC.

☐ I authorize you to attach a copy of my current vision report, as requested.

☐ I also authorize you to speak with my DRC Specialist in consultation to provide future services.

Please submit the completed form by mail to:

Disability Resource Center
20 Dodge Hall
Northeastern University
360 Huntington Avenue
Boston, MA 02115

Or by confidential fax: 617-373-7800 or email DRCDocumentation@northeastern.edu

Thank you for your timely assistance with this matter.

Sincerely,

Student Signature	Date
Print Name	NU ID#

Disability Disclosure Form – Vision Impairment

This form must be completed by the licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document.

Please thoroughly complete this form to document the substantial limitations that are linked to this disability.

1. **Diagnosis/Description of Disability:** ____________________

2. **Please provide full DSM or ICD-9 code:** ____________________

3. **Initial Date of Diagnosis:**____________________ ▪ **Date of last clinical contact:** ____________

4. **Expected duration of disability noted above is:**

☐ Permanent
☐ Chronic
☐ Long term (3---12 months)
☐ Short term (60---90 days)
☐ Temporary (1---60 days)

5. **The extent of the disability is:** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

6. **Assessment Instruments and Results** (*Please describe the procedures, assessment tools, etc. used to establish the diagnosis*)**:**

7. Please describe the student's history of difficulties with his/her disability. Please include both general and academic areas of impact:

8. **Please describe the functional impact of the disability/symptoms on this individual's:**
   i. **Daily life** (*include any limitations related to personal care, social interactions, manual tasks, etc.)*

   ii. **Academic experience** (*note: please consider situations in and out of the classroom*

9. **Please comment on the following items as applicable:**

   - **Visual acuity**: Right Eye____________________ Left Eye______________
   - **Preferred Lighting** (*natural, fluorescent, incandescent, etc.*): ____
   - **Night vision**: ____

10. **Rate Mobility and Orientation** (*travel skills*): **Novice** **Intermediate** **Advanced**

11. **Areas needing improvement**: ____

    ____

12. **This person uses any or all of the following** *(check specific device or service)***:**

   - ☐ Access to print materials (*circle all that apply*):
     Audio Braille Large Print
   - ☐ Assistive technology/software (*please specify*):
     ____
   - ☐ Guide dog
   - ☐ Training center if known:
     ____
   - ☐ Long White or Collapsible Cane
   - ☐ Other technology for mobility (*please specify*):
     ____
   - ☐ Other (*please specify*): ____________________
   - ☐ Public transportation or Paratransit

13. **Suggested Accommodation(s) for the academic setting:**

   - ☐ Access to Online Information
   - ☐ Access to Print Materials
   - ☐ Lab or Classroom Aide
   - ☐ Note---taking/Recorded lectures
   - ☐ Other (*please specify*):
     ____

14. **Additional information:**

Clinician's name: ____

Clinician's State Licensure/Certification #: ____

Area of Specialty:______________________________ **Clinician's phone #:**_________________________

____ ___________________________

Clinician's signature **Date**