

**Blind/Low Vision: Accommodation Support Form**

**NOTE: Please type or print your answers on this form.**

**Student Information**

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

**Cause of Vision Loss**

- |   |   |
|---|---|
| <input type="checkbox"/> Retinal degeneration | <input type="checkbox"/> Albinism                 |
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Glaucoma                 |
| <input type="checkbox"/> Muscular problem     | <input type="checkbox"/> Corneal disorder         |
| <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> Congenital disorder      |
| <input type="checkbox"/> Infection            | <input type="checkbox"/> Cortical                 |
| <input type="checkbox"/> Trauma               | <input type="checkbox"/> Other Please list. _____ |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please give brief explanation of cause. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Severity of Loss**

- |   |                            |                            |                              |
|---|----------------------------|----------------------------|------------------------------|
| <b>Severity of Loss</b>                 | <b>Eye Affected</b>        |                            |                              |
| <input type="checkbox"/> No vision loss | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> R&L |
| <input type="checkbox"/> Mild           | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> R&L |
| <input type="checkbox"/> Moderate       | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> R&L |
| <input type="checkbox"/> Severe         | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> R&L |
| <input type="checkbox"/> Total          | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> R&L |

\_\_\_\_\_

**Age of Onset**

Age of onset \_\_\_\_\_ Date of onset \_\_\_\_\_

\_\_\_\_\_



