Ophthalmological Certification Form

Disability Resource Center

San José State University
Disability Resource Center▪One Washington Square▪San José, CA 95192-0168
Voice: 408-924-6000▪Fax: 408-924-5999▪TTY: 408-924-5990

♦ *To be completed only by M.D. specializing in Ophthalmology*

Patient Name (Please Type or Print) ______________________

Date of Examination ______________________

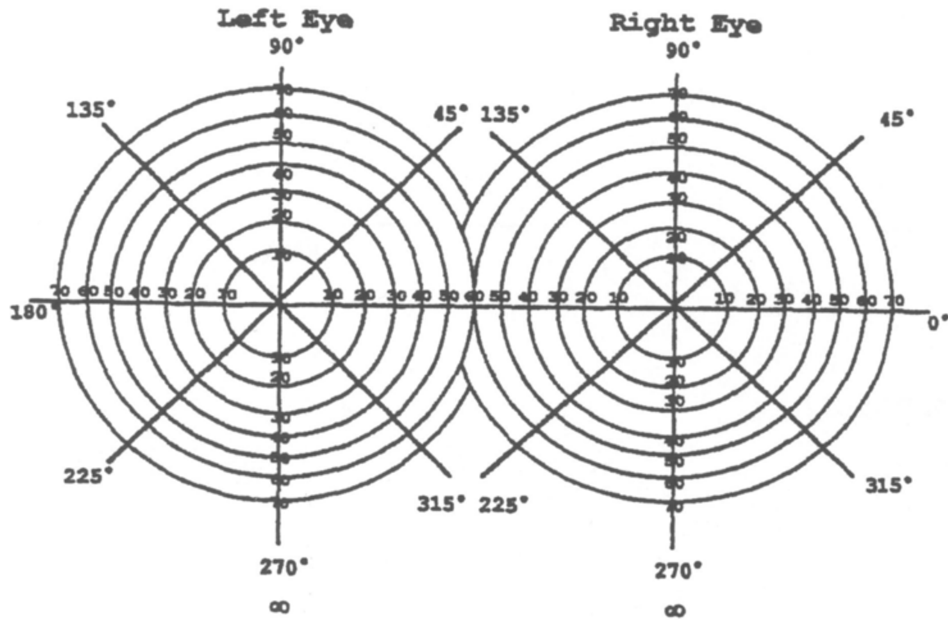
1. Specific diagnosis:

2. Prognosis:

3. Please complete or attach copies of acuity prescription information:

Visual Acuity Without Glasses or Contact Lenses		New Prescription		Corrected Visual Acuity
	Distant	New Rx	Far Rx	
R				
L			L	
	Near	Add + ______	Near Rx	
R			R	
L			L	
	Near at: inches	☐ Glass ☐ Single ☐ Trifocal ☐ Frame ☐ Plastic ☐ Bifocal ☐ Contact Lenses ☐ Tint		Near at: inches

4. Please complete or attach copies of visual fields:



5. Ophthalmoscopic findings:

6. Describe briefly functional limitations, e.g. inability to see writing on a chalkboard or looking through a microscope:

7. Treatment and ongoing care recommended (e.g. medications); side effects that impair physical functioning or performance:

8. Recommended or prescribed low vision aides:

9. In your opinion does the patient need:		
	Yes	No
Large print	________	________
Braille	________	________
Recorded materials	________	________
Electronic text	________	________

Examining Physician Name (Please Type or Print) ____________________ Phone Number ____________________

Address ____________________ City ____________________ State __________ Zip __________

License Number ____________________ Signature ____________________ Date ____________________

***Note:* If additional space is needed please attach extra paper.**