NSW Education Standards Authority

2023 Disability Provisions - Health Professional Information Form (Vision)

Important information

This form is used by the NSW Education Standards Authority (NESA) to confirm a student's disability and evaluate its impact on the student's functioning in an exam setting.

Information for schools & person providing form to health professional

- An **ophthalmologist**, **orthoptist** or **optometrist** must complete this form. They must not be related to the student or have a relationship that could be seen as a conflict of interest.
- Only **one** health professional should complete this form. If multiple health professionals need to contribute information, each one should complete a separate form.
- **Only** the health professional must complete this form. If this form is not completed in full by the health professional and signed as directed the application may be declined.
- Do not write ANYTHING on this form, including the student's name. The health professional is the only person who should write on this form.
- Providing false or fraudulent information, including editing or adding to the health professional's comments, is a breach of HSC rules. The Examination Rules Committee may deem this malpractice and impose a penalty on the student's HSC results.

Information for health professionals:

- Answer **EVERY** question on the form. If you do not have the answer to a question, write "N/A" or "Unknown". **Do not leave any questions blank.**
- Sign **EVERY** page.
- Complete this form **no earlier than Term 4** of the year prior to the HSC exams.
- Any amendments to this form must be initialled and dated.
- If the patient provided you with a form that had any questions pre-answered, including the patient's name, please ask them for a blank copy.
- Answer all questions based on your own professional opinion.

Details of the person who completed this form

Do not sign this form if anyone other than you has written on it.

Name: _____

Profession: _____

Place of work/organisation: _____

Registration number: _____

Telephone: _____

Signature: _____ DIGITAL SIGNATURES WILL NOT BE ACCEPTED

Date: ____ / ____ / ____

Patient's name: DO NOT PRE-FILL THIS OR ANY OTHER SECTION FOR THE PERSON COMPLETING THIS FORM

Diagnosis:

Date of diagnosis: ____/____/____

Visual Acuity (VA)

VA. (near): VA (distance):

VA (near) corrected*: VA (distance) corrected*:
** If appropriate* **If appropriate*

Restricted field of vision (if appropriate):

Describe how the patient's vision impairment when corrected (if appropriate) will affect their performance in the HSC exams in October/November:

What disability provisions do you recommend to address the patient's disability in the HSC exams in October/ November (e.g. N18 sized print)?

Provision	Describe how the provision is expected to relieve the impact of the patient's condition.

Other comments:

Signature of person completing this form:

SIGN HERE PLEASE!