Eye Examination Report

Patient's Name ______________ Date of Birth ______________ Social Security No. ______________

Address ______________ City ______________ State ________ Zip ________

Attention Eye Care Specialist

Address **each** item below.

Your thoroughness in completing this report is essential for this patient to receive appropriate materials and educational services.

Ocular History (e.g., previous eye diseases, injuries, or operations)

Age of onset ________ History ______________

Visual Acuity

If the acuity **can** be measured, complete this box using Snellen acuities or Snellen equivalents or NIL, LP, HM, CF.

Without Glasses		With Best Correction	
Near	Distance	Near	Distance
R	R	R	R
L	L	L	L

Acuity with glare testing, if applicable: R ________ L ________

If the acuity **cannot** be measured, check the most appropriate estimation.

☐ Legally Blind

☐ Not Legally Blind

Muscle Function ☐ Normal ☐ Abnormal Describe ______________

Intraocular Pressure Reading R ________ L ________

Visual Field Test

☐ There is no apparent visual field restriction.

☐ There **is** visual field restriction. Describe ______________

☐ Yes ☐ No The visual field is restricted to 20 degrees or less.

Color Vision ☐ Normal ☐ Abnormal

Photophobia ☐ Yes ☐ No

Diagnosis (Primary cause of visual loss)

—OVER—

Prognosis

☐ Permanent ☐ Recurrent ☐ Improving
☐ Progressive ☐ Communicable ☐ Can Be Improved

Treatment Recommended

☐ Glasses

☐ Patches (Schedule):

R ______________________________

L ______________________________

☐ Medication ____________________

☐ Refer for other medical treatment/exam:

____

☐ Low Vision Evaluation

☐ Other ____

☐ Surgery

☐ Hospitalization will be needed for approximately

______________ days.

Name of hospital ______________________________

____

Name of anesthesiologist or group:

____

Precautions or Suggestions (e.g., lighting conditions, activities to be avoided, etc.)

____

____

Scheduling Date of Next Appointment ____________________ Time ______________

IMPORTANT **Check the most appropriate statement.**

☐ This patient appears to have no vision.
☐ This patient **has a serious visual loss** after correction.
☐ This patient **does not have** a serious visual loss after correction.

Print or Type Name of Licensed Ophthalmologist or Optometrist

Signature of Licensed Ophthalmologist or Optometrist

Address

Date of Examination

City State Zip

( )
Telephone Number

RETURN COMPLETED FORM TO:

Name

Address

Agency

City State Zip

This form should be used when an ophthalmological/optometric examination is needed for (the): ● School Districts ● Special Education Programs● Early Childhood Programs ● Early Childhood Intervention Programs (ECI) ● Eye Screening Follow-Up Examinations ● State DeafBlind Projects