Eye Examination Report

Patient's Name _____ Date of Birth _____ Phone # _____

Address _____ City _____ ZIP _____

Attention Eye Care Specialist

Address **each** item below.

Your thoroughness in completing this report is essential for this patient to receive appropriate 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, Snellen equivalents or NLP, LP, HM, CF.

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

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

Refraction OD _____

OS _____

☐ 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** a field restriction. Describe _____

☐ The visual field **is** restricted to 20 degrees or less.

Color Vision ☐ Normal ☐ Abnormal Describe: _____

☐ Unknown

Diagnosis (Primary cause of visual loss)

_____

_____

Prognosis

- ☐ Permanent
- ☐ Progressive
- ☐ Recurrent
- ☐ Stable
- ☐ Can Be Improved
- ☐ Improving

Treatment Recommended

- ☐ Glasses
- ☐ Patches (Schedule):
  - R _____
  - L _____
- ☐ Medication: _____
- ☐ Low Vision Evaluation
- ☐ Other _____
- ☐ Surgery: _____
  _____
  _____
  _____
- ☐ Referral for other medical treatment/exam:
  _____

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.
- ☐ This patient appears to have a cortical vision impairment.

_____ _____
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:

Teacher Consultant for the Visually Impaired
Cheboygan-Otsego-Presque Isle Educational Service District
6065 Learning Lane
Indian River, MI 49749
(231) 238-9394
(231) 238-8551 FAX

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