

EYE EXAMINATION REPORT

ATTENTION EYE CARE SPECIALIST: Your thoroughness in completing this report is essential for this child/student to receive appropriate educational services.

Student Name _____ Sex M F Date of Birth _____

Parent or Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

EYE EXAMINATION DATE _____

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

Age of onset _____

History: _____

Ocular Medications: _____

II. Measurements

Visual Acuity -- If the acuity can be measured, complete this box using Snellen acuities or Snellen equivalents or NLP,LP, HM, CF, LB (legally blind) Please report best corrected vision.

<input type="radio"/> With Glasses <input type="radio"/> Without Glasses		Prescription				
		<i>Sph.</i>	<i>Cyl.</i>	<i>Axis</i>	<i>Add</i>	
Near	Distance	OD				
		OS				
R (OD)		Does this child/student meet the definition of cortical/neurological visual impairment? <input type="radio"/> Yes <input type="radio"/> No				
L (OS)						
B (OU)		Is the child/student legally blind from a field restriction of 20 degrees or less? <input type="radio"/> Yes <input type="radio"/> No				

Is there a documented field loss? Explain _____

Is there impaired color vision? Explain _____

Is muscle function: _____ normal _____ abnormal? Explain _____

Was an optical device prescribed? Specify type and recommendations

III. Diagnosis. Primary cause of visual loss. If appropriate, indicate OD, OS, OU.

<input type="checkbox"/> Albinism <input type="checkbox"/> Aniridia <input type="checkbox"/> Astigmatism <input type="checkbox"/> Aphakia <input type="checkbox"/> Coloboma <input type="checkbox"/> Congenital Cataracts <input type="checkbox"/> Cataracts	<input type="checkbox"/> Cortical Visual Impairment <input type="checkbox"/> Delayed Visual Maturation <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hyperopia <input type="checkbox"/> ROP <i>Stage</i> _____ <input type="checkbox"/> RP	<input type="checkbox"/> Myopia _____ <input type="checkbox"/> Nystagmus _____ <input type="checkbox"/> Optic Atrophy _____ <input type="checkbox"/> Optic Nerve Hypoplasia <input type="checkbox"/> Strabismus <input type="checkbox"/> Other: _____ _____
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Prognosis: Stable Deteriorating Capable of improvement Uncertain

Recommended Treatment: Glasses Patching Medication Surgery
 Low vision evaluation Other/Comments _____

Glasses: Worn constantly Distance only Near only Sunglasses/tinted lenses

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

Name of Examiner (please print) _____ **M.D.** **O.D.**

Signature of Examiner _____ **Date** _____ **Phone** _____

<p>Questions or concerns by or referring person:</p> <p>PLEASE ATTACH A COPY OF YOUR CHART NOTE FROM TODAY'S VISIT. THANK YOU.</p>	<p>Physician Response:</p>
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