DEPARTMENT OF EDUCATION

Eye Examination Report Form

Patient Information

Patient's name:	Date of birth:		
Address:	City:	State:	ZIP code:
Parent or Guardian name:	Contact Phone:	Email address:	

Attention eye care specialist: Address each item below
Your thoroughness in completing this report is essential to this patient receiving appropriate educational services.

Ocular History

Age at onset:

Describe the ocular history, including eye diseases, injuries, or operations.

Visual Acuity

If the acuity can be measured, complete the section below using Snellen acuities or Snellen equivalents, or NLP, LP, HM, or the distance at which the patient sees the 20/200 letter.

Without correction:	Distance right:	Distance left:	Near right:	Near left:	Both Eyes:
With best correction:	Distance right:	Distance left:	Near right:	Near left:	Both Eyes:

If the acuity cannot be measured, indicate the most appropriate estimation below.

☐ Legally blind 20/200 or worse

☐ Estimated acuity between 20/101 and 20/199

☐ Estimated acuity between 20/61 and 20/100

☐ Estimated acuity better than 20/60

☐ Functions at the definition of blindness (for example, CVI)

☐ Legally blind due to visual field of 20 degrees or less in both eyes.

Muscle Function and Intraocular Pressure

Muscle function: ☐ Normal ☐ Abnormal

Describe:

Intraocular pressure reading: Right: Left:

Visual Field Test

Type of field test:
(Attach a copy of the test.)

☐ No apparent visual field restriction exists.

☐ A visual field restriction exists:

Describe the restriction:
The visual field is restricted to:

☐ 21 degrees to 30 degrees	☐ 20 degrees or less
☐ OD (right eye)	☐ OD (right eye)
☐ OS (left eye)	☐ OS (left eye)
☐ OU (both eyes)	☐ OU (both eyes)

Color Vision

Normal	Abnormal

Type of test. Attach a copy of the test.

Environmental Factors

☐ Glare

☐ Light Sensitivity / Photophobia

☐ Night Blindness / Nyctalopia

Prognosis

☐ Permanent	☐ Recurrent	☐ Improving
☐ Progressive	☐ Stable	☐ Can be improved

☐ Unable to determine prognosis at this time.

☐ At risk for vision loss; this patient is under the age of 3 and/or the degree of vision loss cannot be determined.

Treatment Recommended		
Enter X to select all that apply.		
☐ Glasses	Prescription: Right:	Left:
☐ Contacts	Prescription: Right:	Left:
☐ Patching	Right:	Left:
☐ Clinical low vision evaluation to determine:		
☐ Medication:		
☐ Surgery		
☐ Follow-up needed:		
☐ Other:		
☐ Return in:		
Precautions or suggestions (for example, lighting conditions, activities to be avoided):		

Summary
Enter X to select the most appropriate statement.
☐ This patient appears to have no vision.
☐ This patient does not have a serious visual loss after correction, in a clinical setting.
☐ This patient appears to have serious visual loss after correction, in a clinical setting.
☐ This patient has a diagnosis for a progressive medical condition that will result in no vision or a serious visual loss after correction.

Eye Care Specialist Information			
Signature of licensed ophthalmologist or optometrist: **X**			Print or type name of licensed ophthalmologist or optometrist:
Address:			Date of examination:
City:	State:	ZIP code:	Telephone number:

Return completed form to:			
Name:			
Address:			
City:	State: MN	Zip Code:	
Teacher of the Blind / Visually Impaired (TBVI) or Local Education Agency (LEA):			
TBVI or LEA email address:			
TBVI or LEA Fax Number:			