Medical Eye Examination Report

Patient's Name _____ Date of Birth _____
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 services. ***Starred Items indicate Very Important Information***.

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 NLP, 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 _____

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

- ☐ Legally Blind by VA___ Fields __
- ☐ Not Legally Blind
- ☐ Better than 20/200 down to 20/70
- ☐ Better than 20/70

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

Color Vision ☐ Normal ☐ Abnormal

Photophobia ☐ Yes ☐ No

Diagnosis (Primary cause of visual loss)

★ **Prognosis** ☐ Permanent ☐ Recurrent ☐ Improving ☐ Unable to determine Prognosis at this time

☐ Progressive ☐ Communicable ☐ Can Be Improved

Treatment Recommended

☐ Glasses

☐ Patches (Schedule):

R _____

L _____

☐ Medication _____

☐ Surgery _____

☐ Low Vision Evaluation

☐ Other _____

☐ Refer for other medical treatment/exam:

☐ 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 patients appears to have a serious visual loss after correction in a clinical setting

☐ This patient does not have a serious visual loss after correction in a clinical setting

☐ This patient has a medical diagnosis for a progressive condition that will result in no vision or a serious visual deficit 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 optometric/ophthalmology examination is needed for: Department of Assistive and Rehabilitative Services/DARS Blind Division • School Districts • Special Education Programs • Regional Education Service Centers (ESCs) • Early Childhood Programs (ECH) • Early Childhood Intervention Programs (ECI) • Texas School for the Blind and Visually Impaired (TSBVI) • Eye Screening Follow-Up Examinations • Texas Department of Health (TDH) • Texas Department of Mental Health/Mental Retardation (TDMHMR)