MINNESOTA STATE ACADEMIES

EYE EXAMINATION REPORT

Instructions: Examiner – Complete and Return to:

Minnesota State Academy for the Blind
400 SE 6th Avenue
Faribault, MN 55021-6356
(507) 333-4801

or

Minnesota State Academy for the Deaf
PO Box 308
Faribault, MN 55021

Patient's Name _____ Date of Birth _____ SS 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 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 NLP, LP, HM, CF.

Prescription		
Sph	Cyl	Axis

Without Glasses		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

☐ Legally Blind

☐ Not Legally Blind

Acuity with glare testing, if applicable: R ___ L ____

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 visual 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
☐ 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/Optometrist | Signature of Licensed Ophthalmologist/Optometrist

_____ _____

Address | Date of Examination

_____ _____

City State Zip | (Area Code) Telephone Number_____