State of Texas Interagency Eye Examination Report

Patient Information

Patients Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Parent's or Spouse's Name: _____ Home Phone: _____ Cell phone (optional): _____ Email: _____

Attention eye care specialist

Starred Items Indicate Required Information

Address **each** item below.

Your thoroughness in completing this report is essential to this patient receiving appropriate services.

Ocular History

Age of 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 Snell equivalents, or NLP, LP, HM or the distance at which the patient sees the 20/200 letter.

	NEAR RIGHT	NEAR LEFT	NEAR BINOCULAR	DISTANCE RIGHT	DISTANCE LEFT	DISTANCE BINOCULAR
WITHOUT CORRECTION						
WITH BEST CORRECTION						

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

☐ Legally Blind 20/200 or worse ☐ Between 20/70 and 20/199

☐ Legally Blind due to a visual field of 20 degrees or less in both eyes ☐ Better than 20/70

☐ Functions at the Definition of Blindness (e.g., Cortical/Cerebral Visual Impairment (CVI))

Visual Field Test

Name and type of Field Test: (attach a copy if available): _____

☐ No apparent visual field restriction exists ☐ A visual field restriction exists

Describe the restriction: _____

The visual field is restricted to: OD (Right Eye): ☐ 20° or less ☐ 21° to 30° ☐ Greater than 30°

OS (Left Eye): ☐ 20° or less ☐ 21° to 30° ☐ Greater than 30°

Muscle Function and Intraocular Pressure

Muscle Function: ☐ Normal ☐ Abnormal

Describe: _____

Intraocular pressure reading: Right: _____ Left: _____

Color Vision and Photophobia

Color Vision: ☐ Normal ☐ Abnormal Photophobia: ☐ Yes ☐ No

Type of test: (attach a copy if available): _____

Diagnosis

Diagnosis (primary cause of vision loss): _____

Summarize the diagnosis: _____

ICD 10 Code (TWC): _____ ICD 10 Code (TWC): _____

Prognosis

☐ Permanent ☐ Recurrent ☐ Improving
☐ Progressive ☐ Stable ☐ Can be improved
☐ Unable to determine prognosis at this time

Treatment Recommended

Select all that apply:

☐ Glasses Prescription: Right: _____ Left: _____
☐ Contacts Prescription: Right: _____ Left: _____
☐ Patches 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):_____

_____

Findings

Select the most appropriate statement:

☐ This patient appears to have **no vision**.
☐ This patient appears to **have a 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 visual loss after correction.
☐ This patient **does not have a visual loss** after correction, in a clinical setting.

☐ This patient is **under the age of 3** and/ **OR** the degree of vision loss cannot be determined.

Eye Care Specialist Information

_____ _____
Print or type name of licensed ophthalmologist or optometrist Signature of licensed ophthalmologist or optometrist:

Address:_____ Date of examination: _____

City: _____ State: _____ Zip Code: _____ Telephone Number: _____ Fax Number: _____

Return Completed form to: _____

Address: _____ City: _____State: _____ Zip Code: _____

Agency: _____ Telephone Number: _____Fax Number: _____

This form may be used when an ophthalmological/optometric examination is needed. It was revised by members of the Texas Action Committee for the Education of Students who are Blind or Visually Impaired. This form may be printed as needed.