

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 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.
☐ This patient **does not have a serious 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

Address: _____

City: _____ State: _____ Zip Code: _____

Signature of licensed ophthalmologist or optometrist: _____

Date of examination: _____

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.