OPPORTUNITIES FOR OHIOANS WITH DISABILITIES AGENCY

REPORT OF EYE EXAMINATION

Name _____ Birth Date _____

Date of onset eye pathology _____ Right eye _____ Left eye _____

Diagnosis of visual loss

Right eye _____

Left eye _____

Pathological conditions responsible for visual problems

Right eye _____

Left eye _____

Present treatment

Right eye _____

Left eye _____

If there is a history of eye injury or operation, state type and date

Right eye _____

Left eye _____

VISUAL ACUITY: USE SNELLEN NOTATION

	WITHOUT GLASSES		**WITH BEST POSSIBLE CORRECTION**	
	Distance (20 feet)	**Near (14 inches)**	**Distance (20 feet)**	**Near (14 inches)**
Right eye	_____		_____	
Left eye	_____		_____	

REFRACTION RECORD

	Sphere	**Cylinder**	**Axis**	**Prism**
Right eye	_____	_____	_____	_____
Left eye				

Cycloplegic? Yes ☐ No ☐ Are glasses prescribed?' Yes ☐ No ☐

Is light projection accurate? Right eye _____ Left eye _____

Is new prescription indicated? Yes ☐ No ☐

Are other visual aids indicated (contact lenses, low vision aids, etc.)? _____

Other factors affecting visual functioning (e.g., diplopia, photophobia, night blindness, etc.):

_____

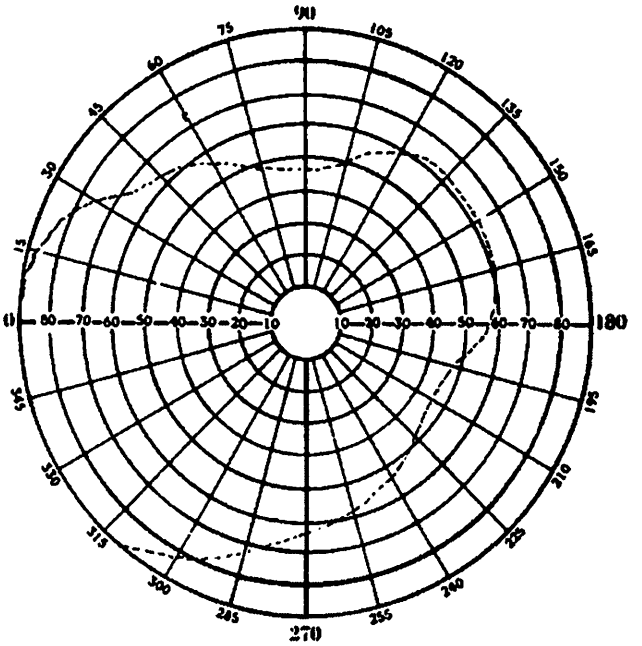
_____

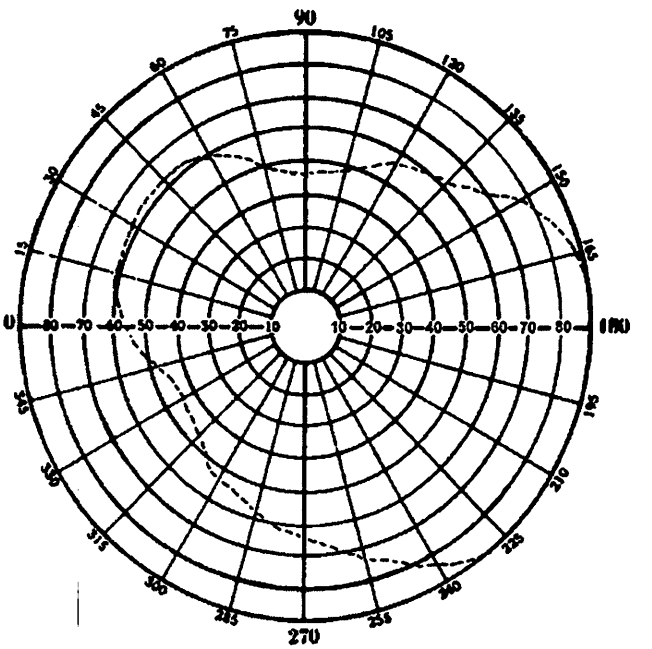
_____

_____

_____

Please complete diagrams if field loss is significant.





Degree of visual field remaining OD _____ OS _____

Visual fields: Normal _____ Not able to be tested _____ Not indicated _____

Abnormal (recorded above) _____

Method _____ Reliability _____

Prognosis (is there any likelihood that vision could be restored by operation or treatment?)

_____

_____

The condition is: static _____ progressive _____

Recommendations for restoration: _____ Not possible

_____ May be accomplished by:
1. Surgery (type)
2. Medical treatment (type)
3. Visual aids (type)

Environmental factors which aggravate eye pathology (light, smoke, dust, etc.)

_____

_____

Comments:

Signature _____

_____ _____

Examining Ophthalmologist or Optometrist (please print or type) Date of examination

Please fax to: Sharon Valade, (614) 985-9806