WSSB Eye Examination Report

Patient's name: Date of Birth:

Address: City: State: ZIP Code:

Parent/Spouse Name: Phone H: Cell: Email:

Attention Eye Care Specialist

Starred Items indicate Required Information

Address **each** item below

Your thoroughness in completing this report is essential for this patient to receive appropriate services

Ocular History (e.g., prematurity, previous eye diseases, injuries or surgeries)

Age of onset: History:

★ **Visual Acuity (VA)**

If the acuity **can** be measured, complete this box using Snellen acuities or Snellen equivalents or NLP, LP, HM, or distance at which the patient sees the 20/200 letter.

Without Correction		With Best Correction	
Near	Distance	Near	Distance
R	R	R	R
L	L	L	L

★ *** IMPORTANT ***

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

- ☐ Legally Blind 20/200 or worse
- ☐ Between 20/70 and 20/199
- ☐ Better than 20/70
- ☐ Functions at the Definition of Blindness (e.g., CVI)

Muscle Function: ☐ Normal ☐ Abnormal Describe:

Intraocular Pressure Reading: Right: Left:

★ **Visual Field Test** Type of Field Test: (Confrontation Not Acceptable)

☐ There is no apparent visual field restriction.

☐ There is a visual field restriction. Describe:

☐ The field is restricted to: ☐ 21 degrees to 30 degrees ☐ 20 degrees or less

Color Vision ☐ Normal ☐ Abnormal

Type of test:

Photophobia ☐ Yes ☐ No

★ **Diagnosis** (primary cause of visual loss):

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

☐ Progressive ☐ Stable ☐ Can be improved

☐ At risk for vision loss; this consumer is under 3 and/or the degree of vision loss cannot be determined

Treatment Recommended

☐ Glasses Prescription: Right: Left:

☐ Contacts Right: Left:

☐ Patches (Schedule): Right: Left:

☐ Clinical Low Vision Evaluation to determine:

☐ Medication:

☐ Surgery:

☐ Follow-up needed:

☐ Other:

☐ Return in:

Precautions or suggestions (e.g., lighting conditions, activities to be avoided, etc.)

Check the most appropriate statement

☐ This patient appears to have no vision

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

☐ This patient appears to have a 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

Print or Type Name of Licensed Ophthalmologist or Optometrist	X **Signature of Licensed Ophthalmologist or Optometrist**
Address:	Date of examination:
City: State ZIP Code:	Telephone number: Fax number:

RETURN COMPLETED FORM TO: Name:

Address: City: State ZIP Code:

Agency: Telephone number: Fax number:

This form may be used when an ophthalmological/optometric examination is needed.