**Eye Report for Students with Visual Impairments**

*To be completed by an ophthalmologist or optometrist*

**Student Name:**       **Date of Birth:**

**Name of Doctor:**       Ophthalmologist [ ]  Optometrist [ ]

Doctor’s Address:

Doctor’s Email:       Phone:       FAX:

Date Form Sent to Doctor:       Date of Last Eye Exam:

**Visual Diagnosis:**

Age of Onset:      Prognosis:

**Acuities, best corrected for near and distance.** Please indicate the type of acuity test used.

Distance: OD      OS      OU       Test used

Near: OD       OS       OU       Test used

**Note:** FDB (Functions at the Definition of Blindness) may be used if no ocular pathology is diagnosed but child functions as blind.

Does the student meet this criterion? Yes [ ]  No [ ]

**Alternate Acuity Testing?** Yes [ ]  No [ ]  Please describe:

**Glasses Prescribed?** Yes[ ]  No [ ]  If so, please indicate purpose(s):

Full-time wear [ ]  Near viewing only [ ]  Distance only [ ]  Bifocal [ ]  Protective [ ]

**Prescription for Glasses:**

OD       OS

**Visual Field:** Describe any field constrictions or preferences. Please indicate test used, and describe testing procedure. Attach any visual field charting.

**Low Vision Devices Recommended?** Yes [ ]  No [ ]

If so, list non-optical and optical, power, type, and purpose.

Is follow-up recommended? Yes [ ]  No [ ]

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**Alignment/Binocularity/Motility Concerns?** Yes [ ]  No [ ]

If yes, please describe

**Eye Patching Program Recommended?** Yes [ ]  No [ ]

If so, please describe:

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**Treatment Plan** (i.e., medication, surgery, patching, referral for additional testing): Yes [ ]  No [ ]

**Other Medical Diagnoses, Relevant Medical Information, or Comments in General** (i.e., other systemic conditions, medication prescribed):

**Do you have any questions or additional comments for the evaluation team?** If so, please elaborate.

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Signature of Eye Doctor

**Please return this form to:**

Name/Title:

Address:

Phone:       FAX: E-mail: