**Department for Children and Families**
**Rehabilitation Services**

# Low Vision Examination Report

Name _____ D.O.B. _____

Examiner _____ Date _____

Primary Eye Care Practitioner _____

History:

Diagnosis:

Present Optical & Non-optical aids:

Patient Primary Concern:

Other:

_____

Acuity with present $R_x$ (chart used?)

| | Distance | Near | Present Prescription |
|---|---|---|---|
| O.D. | | | |
| O.S. | | | |
| O.U. | | | |

Acuity with new $R_x$ (chart used?)

| | Distance | Near | Present Prescription |
|---|---|---|---|
| O.D. | | | |
| O.S. | | | |
| O.U. | | | |

Response to Magnification and aids tried

Comments:_____

_____

_____

_____

Field of Vision: _____

Test Administered: (Please enclose copy) _____

Field Explanation & Functional Implications:

_____

_____

_____

_____

_____

Miscellaneous Procedures (Keratometry, color vision, contrast sensitivity, amsler grid):

_____

_____

_____

_____

_____

Sun & Glare Reduction Lenses:

_____

_____

_____

_____

Prescription ($R_x$, low vision aids, etc.):

_____

_____

_____

_____

_____

Recommendations (Individualized low vision aid instruction, i.e.; focal distance, working distance, illumination, etc.):

_____

_____

_____

_____

_____

_____
Signature

_____
Date

Send Report to the following address:

_____

_____

_____