Kansas Department for Children and Families
Rehabilitation Services

REPORT OF EYE EXAMINATION

Patient's Name _____ Sex _____
(First) (Middle) (Last)

Address _____
(Number and street)(City) (County) (State) (Zip)

Date of Birth _____ Place of Birth _____
(Month) (Day) (Year) (State)

I. History

A. Age at onset of blindness: Right eye O.D. _____ Left eye O.S. _____

B. Record ocular infections, injuries, operations, hereditary factors. If injury, indicate circumstances. If hereditary, indicate if blood relatives have same condition.

_____

_____

II. Diagnosis (es)

A. Primary eye condition: O.D. _____
Record condition responsible for visual impairment. O.S. _____

B. Secondary ocular condition, if any. O.D. _____
O.S. _____

C. Etiology of primary eye condition, e.g., disease, injury, hereditary or other prenatal influence. O.D. _____
O.S. _____

III. Describe External Appearance of the Eyes – Pupils, Reactions and Fundi:

O.D. _____
O.S. _____

IV. Intra-ocular Pressure

If tension is not measured with Schiotz tonometer, specify instrument used.

Tension in mm O.D. _____ O.S. _____ Gm. Wgt. _____

V. Vision Measurements:

A. Central Visual Acuity:

	WITHOUT CORRECTION		WITH BEST CORRECTION		CORRECTION NEEDED
	distance	near	distance	near	(If glasses prescribed)
O.D.					
O.S.					

B. Field of vision: If field limitation is indicated, test of field vision should be made and test results attached.

VI. Prognosis and Recommendations:

A. Patient's vision is considered: stable _____ deteriorating _____
capable of improvement _____ uncertain _____

B. Is this person legally blind? Yes _____ No _____

C. Treatment recommended:

_____

_____

_____

D. Re-examination advised? Yes _____ No _____ If yes, date _____

E. Other recommendation:

_____

_____

Send Report to the following address:

_____

_____

_____

Date of Examination _____ Signature of Examiner _____