Medical Eye Report

Patient Information

Name: _____

Date of Birth: _____

Street Address: _____

Best Phone: _____ Alternate phone: _____

Contact Person

Name: _____

Relationship to Patient: _____

Best phone: _____ Alternate phone: _____

Email: _____

Diagnosis (w/ ICD code):	**OD**	**OS**
Primary		
Secondary		

Prognosis (circle as appropriate):

Stable Guarded Recovering Unknown Progressive/Deteriorating

Distance Acuity:

	w/o correction	w/ correction
OD		
OS		

Near Acuity:

	w/o correction	w/ correction
OD		
OS		

Visual Field Limitation: Yes No Unknown

Degrees Remaining:

OD:
OS:

Other description:

Is this Patient Legally Blind? **Yes** **No**

If not Legally Blind, does this Patient have Impaired Vision? **Yes** **No**
(central visual acuity does not exceed 20/70 in the better eye with correcting lenses)

If unable to accurately measure acuity or visual field levels, does Patient's observed functional vision meet the definition of:
Legally Blind: **Yes** **No** Impaired Vision: **Yes** **No**

Reason an exact measure of acuity or visual field levels could not be obtained :_____

_____

Are glasses or low vision aids prescribed? **Yes** **No**

If so, please describe, and indicate when they should be used: _____

_____

_____

_____

Date of Exam: _____

Practitioner Name: _____

Discipline of Practitioner: Ophthalmologist Other MD Optometrist APRN

Name of Practice:_____

Street Address:_____

City/State/Zip:_____

Phone:_____

_____

Practitioner Signature: **Date:**