**Eye Examination Report**

**Attention Eye Care Specialist**
Address each item below.
Your thoroughness in completing this report is essential for this patient to receive appropriate educational services.

**Ocular History** (e.g. previous eye diseases, injuries, or operations)
Age of onset ___________________ History ___________________

**Visual Acuity**
If the acuity **can** be measured, complete this box using Snellen acuites, Snellen equivalents or NLP, LP, HM, CF.

<table>
<thead>
<tr>
<th>Without Correction</th>
<th>With Best Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Near</strong></td>
<td><strong>Distance</strong></td>
</tr>
<tr>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>L</td>
<td>L</td>
</tr>
</tbody>
</table>

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

- [ ] Legally Blind
- [ ] Not Legally Blind

**Muscle Function**  
☐ Normal  ☐ Abnormal  Describe: __________________________

**Intraocular Pressure Reading**
R _______  L _______

**Visual Field Test**
- [ ] There is no apparent visual field restriction.
- [ ] There is a field restriction. Describe: __________________________
- [ ] The visual field is restricted to 20 degrees or less.

**Color Vision**  
☐ Normal  ☐ Abnormal  Describe: __________________________
- [ ] Unknown

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Diagnosis (Primary cause of visual loss)

Prognosis
☐ Permanent  ☐ Recurrent  ☐ Can Be Improved
☐ Progressive  ☐ Stable  ☐ Improving

Treatment Recommended
☐ Glasses
☐ Patches (Schedule):
R __________________________
L __________________________
☐ Medication: __________________________
☐ Low Vision Evaluation
☐ Other __________________________
☐ Surgery: __________________________
☐ Referral for other medical treatment/exam:

IMPORTANT: Check the most appropriate statement.
☐ This patient appears to have no vision.
☐ This patient has a serious visual loss after correction.
☐ This patient does not have a serious visual loss after correction.

Print or Type Name of Licensed Ophthalmologist or Optometrist
Signature of Licensed Ophthalmologist or Optometrist
Address __________________________
Date of Examination __________________________
City __________________________ State ________ Zip __________________________
Telephone Number __________________________

RETURN COMPLETED FORM TO:
Teacher Consultant for the Visually Impaired
Cheboygan-Otsego-Presque Isle Educational Service District
6065 Learning Lane
Indian River, MI 49749
(231) 238-9394
(231) 238-8551 FAX

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