



Educational Service District 123 Eye Examination Report

Patient/Student's Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip Code _____

Attention Eye Care Specialist

Address each item below.



**Your thoroughness in completing this report is essential
for this patient/student to receive appropriate services.**



TODAY'S DATE: _____

OCULAR HISTORY (e.g., previous eye diseases, injuries or operations)

Age of onset _____

DIAGNOSIS (primary cause of visual loss)

Area affected: cornea lens media opacity retina optic nerve cortical

Specific Conditions: _____

PROGNOSIS: Permanent Recurrent Improving
 Progressive Communicable Can Be Improved

VISUAL ACUITY

If the acuity can be measured, complete this box using Snellen acuities or Snellen equivalents or NLP, LP, HM, CF.

Without Glasses

With Best Correction

Without Glasses		With Best Correction	
Near	Distance	Near	Distance
R	R	R	R
L	L	L	L

VISUAL FIELD TEST

- There is no apparent visual field restriction.
- There is a field restriction. Describe: _____
- Yes No The visual field is restricted to 20 degrees or less.

IMPORTANT—CHECK THE MOST APPROPRIATE STATEMENT

- 1. Patient/Student has a visual acuity of 20/70 or less in the better eye with correction; or
- 2. Patient/Student has a field of vision which at its widest diameter subtends an angle of no greater than twenty degrees in the better eye with correction
- 3. Patient/Student has an eye condition, either an eye pathology or a progressive eye disease which is expected to either reduce acuity or field to the criteria stated in 1 or 2 above.
- 4. Patient/Student has cortical damage.

Patient/Student's Name _____

MUSCLE FUNCTION <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	PATIENT/STUDENT HAS GLAUCOMA? <input type="checkbox"/> Yes <input type="checkbox"/> No
COLOR VISION <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	PHOTOPHOBIA <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

TREATMENT RECOMMENDED

- Glasses prescribed for: Myopia Hyperopia Astigmatism
- Patches (schedule)
 - R _____
 - L _____
- Surgery
- Medication: _____
- Refer for other medical treatment/exam: _____
- Low Vision Evaluation
- Other: _____

PRECAUTIONS OR SUGGESTIONS (e.g., lighting conditions, activities to be avoided, etc.)

SCHEDULING

Recommended date of next appointment: _____

Print /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:
Special Services Department
Attn: Vision Services
Educational Service District 123
3918 W Court St
Pasco WA 99301