FAX TO: 401-222-1328

State of Rhode Island
Department of Human Services Office of Rehabilitation Services
Services for the Blind and Visually Impaired
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CONFIDENTIAL
REPORT OF EYE EXAMINATION

Name of Patient: _____ _____ _____
(Last) (First) (MI) (SS#)

Address: _____
(No. and Street) (City/Town) (State) (Zip)

Date of Birth: _____ Telephone: (401)556-7282 Sex: ■M ☐F

I. MEASUREMENTS- with best correction

A. Visual Acuity	Distant Vision	Near Vision
Right Eye (O.D.)	_____	_____
Left Eye (O.S.)	_____	_____
Both Eyes (O.U.)	_____	_____

B. Intraocular Pressure: O.D.: _____ O.S.: _____ Method: _____
C. Fields of vision: Normal ☐ Restricted ☐ **(if restricted, attach copy of formal fields)**

If Restricted Please indicate degree of Restriction _____ OD _____ OS

II. CAUSE OF BLINDNESS OR SEVERE VISUAL IMPAIRMENT

A. Ocular condition(s) responsible for visual impairment, (If more than one, specify all but list primary cause of visual impairment on the first line.) (Circle One)

_____ OU / OD / OS

_____ OU / OD / OS

B. Etiology (underlying cause) of ocular condition primarily responsible for visual impairment (e.g. specific disease, injury, poisoning, heredity or prenatal influence).

_____

_____

III. HISTORY

A) Probable age at onset of severe visual impairment _____
B) Severe ocular infections, injuries, if any (with age at time of occurrence) _____
C) Could this condition be hereditary? _____

IV. PROGNOSIS AND RECOMMENDATIONS

A. Patient's visual impairment is considered to be: Stable _____ Deteriorating _____ Capable of Improvement _____
B. What treatment is recommended, if any? _____
C. Would patient benefit from a low vision evaluation? _____
D. Corrective lens prescription: OD _____ Sph _____ Cyl _____ Axis
OS _____ Sph _____ Cyl _____ Axis
Add: _____

Name of Examiner (please print or type): _____MD/DO/OD

Signature: _____ Date of Examination: _____