CONFIDENTIAL

ILLINOIS INSTRUCTIONAL MATERIALS CENTER

OCULAR REPORT FOR PERSONS WITH VISUAL PROBLEMS

NAME	SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH
ADDRESS (Street, City, Zip Code)	PARENT OR GUARDIAN		PHONE
ATTENDANCE SCHOOL DISTRICT (Name and Number)	RESIDENT SCHOOL DISTRICT (Name and Number)		GRADE

I. Measurements

INSTRUCTIONS FOR COMPLETING TABLE BELOW

A. **Distant Vision**

Use Snellen notation with test distance of 20 feet. (Examples. 20/100, 20/60) For acuities less than 20/200, record distance at which 200 foot letter can be recognized as numerator of fraction and 200 as denominator. (Examples: 10/200, 3/200)

If the 200 foot letter is not recognized at 1 foot record the abbreviation for best distant vision as follows:

CF and definite distance - counts fingers at definite distance i.e., CF 1'

HM and definite distance - hand movement at definite distance i.e., HM 1'

OP - Object Perception

LP - Light perception (without projection)

NIL - Totally blind

ENUC - Enucleated (eyeball removed)

PROS - Prosthesis (artificial eye)

ANOPH - Anophthalmos (absence of true eyeball)

FB - (Functionally Blind) In examiner's opinion, student's vision is 20/200 or less in better eye with maximum correction.

B. **Near Vision**

Use standard A.M.A. notation.

FILL IN BOTH DISTANT AND NEAR VISION

VISUAL ACUITY	A. DISTANT VISION		B. NEAR VISION		C. PRESCRIPTION			
	WITHOUT CORRECTION	WITH BEST SPECTACLE CORRECTION	WITHOUT CORRECTION	WITH BEST SPECTACLE CORRECTION	SPH.	CYL.	AXIS	ADD
Right Eye								
Left Eye								
Both Eyes					DATE OF ABOVE RX.			

COMMENTS:

VISUAL FIELD RESTRICTION? ☐ Yes ☐ No

If yes, widest remaining visual field (in degrees) **Right** _____ **Left** _____

Significant Field Restriction (please describe) _____

IMPAIRED COLOR PERCEPTION? ☐ Yes ☐ No **Which colors?** _____

OVERALL DIAGNOSIS/ETIOLOGY

RE/ _____

LE/ _____

II. Treatment Recommended

Please check if appropriate:

- ☐ Medication
- ☐ Surgery
- ☐ Glasses ☐ Contact Lenses
  - ☐ Constant Wear
  - ☐ Near Vision Only
  - ☐ Far Vision Only
- ☐ Low Vision Aid
- ☐ Occlusion RE _____ LE _____
- ☐ Low Vision Aid Prescribed:
  - Distant: Type _____ RE _____ LE _____
  - Near Type _____ RE _____ LE _____
- ☐ Lighting Requirements
  - ☐ Average
  - ☐ Other _____
- ☐ Restricted Physical/Recreational Activities
  - ☐ No Restrictions
  - ☐ Restrictions _____
- ☐ Other. _____

VISION PROGNOSIS

Pupil's vision impairment is considered to be:

- ☐ Stable
- ☐ Capable of Improvement
- ☐ Deteriorating
- ☐ Uncertain

RE-EXAMINATION ADVISED

- ☐ Six Months
- ☐ Twelve Months
- ☐ Other _____

COMMENTS:

TYPE OF EXAMINER

- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ EENT
- ☐ Other M.D. (specify) _____

NAME OF EXAMINER

STREET ADDRESS CITY STATE

PHONE NUMBER DATE OF EXAMINATION

_____

Signature of Examiner

Permission granted to use this information for purposes stated on this ocular report form.

_____ _____

Date *Signature of Person, if 18; or Parent or Legal Guardian*

TO BE FORWARDED BY EXAMINER

To:

IF ABOVE NAME AND ADDRESS NOT COMPLETED, FORWARD THIS FORM TO: