State of Texas Interagency Eye Examination Report

Patient's Name: Date of Birth:

Address: City: State: ZIP Code:

Parent/Spouse Name: Phone H: Cell: Email:

Attention Eye Care Specialist

Starred Items indicate Required Information

Address **each** item below

Your thoroughness in completing this report is essential for this patient to receive appropriate services

Ocular History (e.g., prematurity, previous eye diseases, injuries, or surgeries)

Age of Onset: History:

★ **Visual Acuity (VA)**

If the acuity **can** be measured, complete this box using Snellen acuities or Snellen equivalents or NLP, LP, HM, or distance at which the patient sees the 20/200 letter.

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

★ *** IMPORTANT ***

If the acuity **cannot** be measured, enter X to select the most appropriate estimation.

- ☐ Legally Blind 20/200 or worse
- ☐ Between 20/70 and 20/199
- ☐ Better than 20/70
- ☐ Functions at the Definition of Blindness (e.g., CVI)

Muscle Function: ☐ Normal ☐ Abnormal Describe:

Intraocular Pressure Reading: R _____ L _____

★ **Visual Field Test** Type of Field Test: _____ (Confrontation Not Acceptable)

- ☐ There is no apparent visual field restriction.
- ☐ There is a field restriction. Describe: _____

The field is restricted to: ☐ 21 to 30 degrees ☐ 20 degrees or less.

Color Vision ☐ Normal ☐ Abnormal

Type of test:

Photophobia ☐ Yes ☐ No

★ **Diagnosis** (Primary cause of visual loss):

★ **Prognosis** ☐ Permanent ☐ Recurrent ☐ Improving ☐ Unable to determine prognosis at this time

☐ Progressive ☐ Stable ☐ Can be improved

☐ At risk for vision loss; this consumer is under 3 and/or the degree of vision loss cannot be determined.

Treatment Recommended

☐ Glasses Prescription: Right: Left:

☐ Contacts Prescription: Right: Left:

☐ Patches (Schedule): Right: Left:

☐ Clinical Low Vision Evaluation to determine:

☐ Medication:

☐ Surgery:

☐ Follow-up needed:

☐ Other:

☐ Return in:

Precautions or Suggestions (e.g., lighting conditions, activities to be avoided, etc.):

★ **IMPORTANT** ★ **Enter an X to select the most appropriate statement**

☐ This patient appears to have no vision

☐ This patient does not have a serious visual loss after correction, in a clinical setting

☐ This patient appears to have a serious visual loss after correction, in a clinical setting

☐ This patient has a diagnosis for a progressive medical condition that will result in no vision or a serious visual loss after correction

X

Print or Type Name of Licensed Ophthalmologist or Optometrist

Signature of Licensed Ophthalmologist or Optometrist

Address

Date of Examination

City State ZIP Code

( ) Telephone Number

( ) Fax Number

RETURN COMPLETED FORM TO: Name:

Address City State ZIP Code

( ) Agency Telephone Number

( ) Fax Number

This form may be used when an ophthalmological/optometric examination is needed. It was revised by members of the Texas Education of Blind and Visually Impaired Students Advisory Committee. This form may be printed as needed. For additional copies, go to http://www.dars.state.tx.us/dbs/manuals_forms.shtml