Cincinnati Association for the
Blind & Visually Impaired

2045 Gilbert Avenue, Cincinnati, Ohio 45202 • Phone: 513-221-8558 • Fax: 513-221-2995

EYE EXAMINATION REPORT

Date of this report: __________ Telephone: __________

Applicant's Name __________ Birth Date __________

Address __________
(Street) (City) (State) (Zip Code) (County)

VISUAL ACUITY (With Correction)

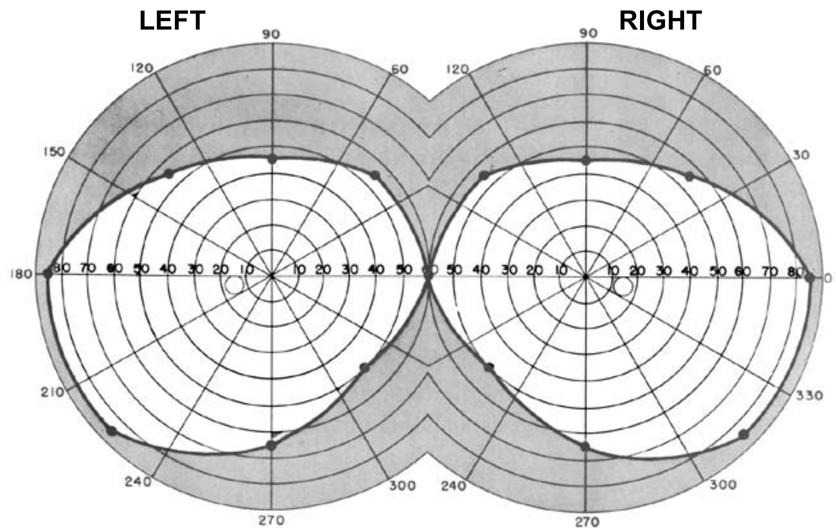
	Far	Near
Right eye		
Left eye		

REFRACTION

Right eye __________
Left eye __________
Add __________

VISUAL FIELDS

PLEASE RECORD OR ATTACH VISUAL FIELDS AS THEY ARE NEEDED FOR LOW VISION TESTING AND REHABILITATION SERVICES



DIAGNOSIS AND DATE OF ONSET

Right eye __________

Left eye __________

PROGNOSIS __________

HISTORY of eye injuries or operations (state type and dates) __________

Names of other doctors providing eye care to this patient (including referrals) __________

SERVICES SUGGESTED

- ☐ Low Vision Services
- ☐ Counseling
- ☐ Early Childhood & Youth Services
- ☐ Orientation & Mobility
- ☐ Rehabilitation Teaching
- ☐ Talking Book Machine
- ☐ Computer Training
- ☐ Industries Program

Additional Remarks (include any restrictions or precautions) __________

In order to meet your patient's rehabilitation needs, it may be helpful to share this report with the State rehabilitation agency. If you have any objections, please indicate here. __________

Signature of Examining Eye Doctor __________

Name __________ Date of examination __________

Address __________

PROTECTED HEALTH INFORMATION STATEMENT

The privacy of all medical records and other individually identifiable health information must be protected at all times. Information relating to a patient's health care history, diagnosis, condition, treatment, or evaluation shall be considered individually identifiable health information. **Confidentiality of this health information must be maintained at all times.** This information has been disclosed to you from confidential records of which may be protected by federal and/or state law. *With regard to its use and/or disclosure of protected health information, the recipient of this information hereby agrees to safeguard all protected health information from misuse of any and all kinds as required by law.*