

## EYE EXAMINATION REPORT

Date of this report: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Applicant's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 (Street) (City) (State) (Zip Code) (County)

### VISUAL ACUITY (With Correction)

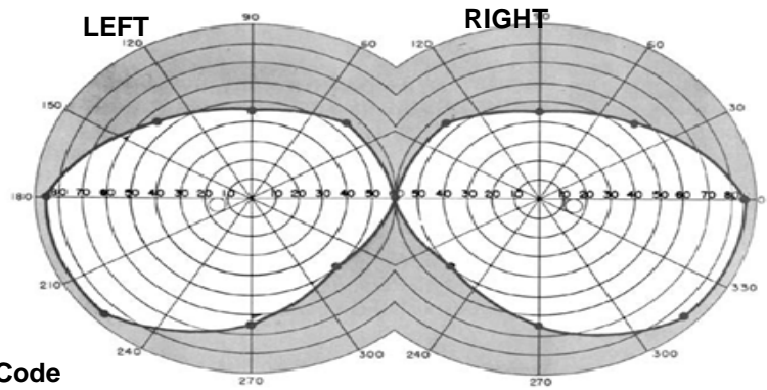
Far Near  
 Right eye \_\_\_\_\_  
 Left eye \_\_\_\_\_

### 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, Dx Medicare Code

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Low Vision Services              | <input type="checkbox"/> Orientation & Mobility  | <input type="checkbox"/> Computer Training  |
| <input type="checkbox"/> Counseling                       | <input type="checkbox"/> Rehabilitation Teaching | <input type="checkbox"/> Industries Program |
| <input type="checkbox"/> Early Childhood & Youth Services | <input type="checkbox"/> Talking Book Machine    |   |

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.*