EDUCATIONAL SERVICE CENTER
of Northeast Ohio

CONFIDENTIAL

ALL PARTS MUST BE COMPLETE

EYE REPORT FOR CHILDREN WITH VISUAL PROBLEMS

Date of Exam _____/_____/_____

Name of Child: _____
(First) (Middle) (Last) (DOB)

Address: _____
(No. and Street)

_____
(City of Town) (County) (State) (Zip)

Name of School: _____ Grade: _____

Address: _____
(No. and Street)

_____
(City of Town) (County) (State) (Zip)

I. HISTORY

A. Primary Cause of visual impairment: _____

B. List any systemic disease(s) contributing to the ocular condition: _____

C. Surgeries (i.e., cataract, strabismic, other): _____

D. Medications: _____
(Please list all ocular and systemic medications)

E. Age of onset of visual impairment: _____

F. Other Handicapping Conditions: _____

II. REFRACTIVE CORRECTION

Current prescription:	OD	OS
Glasses	Contacts	Other
Is a new correction recommended?	Yes	No
If Yes, new prescription	OD	OS

	Distance Visual Acuity Without Correction	Distance Visual Acuity With Correction	Near Visual Acuity Without Correction	Near Visual Acuity With Correction
Right Eye (OD)				
Left Eye (OS)				
Both Eyes (OU)				

	YES	NO	
Is visual field normal:			If no, please attach field chart
Is there evidence of light sensitivity?			
Is there normal color perception?			If no, what color(s)?
Please indicate test used:			

Prognosis: _____Stable _____Deteriorating _____Capable of Improvement

III. RECOMMENDATIONS

	YES	NO	
Low vision examination			
Optical aids			
Glasses			
Special tinted lenses/filters recommended?			Specify:
Wish to see again?			If yes, when:
Preferred lighting?			
Other			

Need for physical restrictions? _____

Doctor's Name (Signature) _____ Date of exam _____

Doctor's Name (Print)_____

Address: _____
(No. and Street)

_____
(City of Town) (County) (State) (Zip)

Return to: Dana Lambacher Educational Service Center of Northeast Ohio
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