LEADER DOGS FOR THE BLIND

1039 S. Rochester Road | Rochester Hills, MI 48307-3115
248.651.9011 ***phone***
clientservies@leaderdog.org ***email***
248.601.3230 ***fax***

Vision Evaluation

(To be completed by an eye care professional)

Applicant Name _____

Date of Last Exam _____ Date of Next Appointment _____

Cause of Vision Loss _____

Is Applicant Legally Blind? ☐ **Yes** ☐ **No** Comment _____
(this question MUST be answered in order for form to be complete)

Visual Acuities: OD _____ OS _____ OU _____

With Correction: OD _____ OS _____ OU _____

Near Vision: OD _____ OS _____ OU _____

Central Fields: OD _____ OS _____ OU _____

Peripheral Fields: OD _____ OS _____ OU _____

If available, please attach copies of visual field results.

Ocular Medications: _____

Does applicant have functional low vision? _____

Fixation: _____

Scanning: _____

Does applicant use low vision aides to travel?_____

Comments _____

_____

_____

Signature _____, M.D./D.O./O.D. Address _____

Name (print) _____ City_____

Telephone _____ State _____ Zip _____

Date _____