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# 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 \_\_\_\_\_