RESET FIELDS

REPORT OF OPHTHALMOLOGICAL EXAMINATION

INSTRUCTION TO EXAMINER: Prepare in TRIPLICATE, typed if possible. RETURN signed original and one copy to the county assistance office. You may keep the third copy. In taking visual acuity use standard test card and report in Snellen notation. If necessary, refraction should be done in order to obtain vision with the best possible correcting glass. When definite information cannot be ascertained from examination or applicant's responses, please give your opinion regarding the degree of visual loss or any information which may help the consulting ophthalmologist to make a decision as to the eligibility of the applicant.

CASE IDENTIFICATION				
CO.	RECORD NUMBER	CAT.	CTR. DIG.	DIST.
RECORD NAME				
WORKER			CASELOAD NO.	

NAME OF EXAMINEE	ADDRESS OF EXAMINEE	AGE	SEX	MARITAL STATUS

NOTE TO OPTOMETRISTS: Please complete the entire form. The sections marked with an asterisk (*) are to be completed in such a way as to provide as much information as is possible within the scope of the practice of optometry. If you believe the applicant should have further examination by an ophthalmologist, please so state.

Physicians who have attended examinee for eyes.	NAME	NAME
	ADDRESS	ADDRESS
Hospital treatment received for any eye condition.	NAME OF HOSPITAL	DATE
	ADDRESS	
If operated on, give type of operation and date for each eye. If otherwise treated, describe.	O.D.	
	O.S.	
*Give exact or reasonable etiologic factors responsible for present eye condition.	O.D.	DATE OF ONSET
	O.S.	DATE OF ONSET
Describe briefly the external findings (oblique illumination and loup slit lamp, tension etc.)	O.D.	
	O.S.	
If visual fields are obtainable with white test object (describe size), hand, or light, describe briefly.	O.D.	
	O.S.	
Describe briefly the fundus if it can be seen.	O.D.	
	O.S.	
*Name disease of eyes leading to visual loss. (DIAGNOSIS)	O.D.	
	O.S.	
*Secondary diagnosis.	O.D.	
	O.S.	

Central visual acuity by Snellen notation in meters or feet.

Please use the applicable designated coding in completing this section.

If vision is too low to be taken at test card, record the distance at which hand movements (H.M.) can be seen shadows (S), light perception (L.P.), blind (B).

		WITHOUT GLASSES		WITH BEST POSSIBLE CORRECTING GLASS	
O.D.	DISTANT	NEAR		DISTANT	NEAR
O.S.	DISTANT	NEAR		DISTANT	NEAR

Visual acuity with best possible correcting glass for distant vision.

PLEASE CHECK ONE OF THE FOLLOWING BLOCKS

☐ 3/60 or 10/200 or less ☐ Better than 3/60 or 10/200

SIGNATURE OF EXAMINER	ADDRESS OF EXAMINER	DATE OF EXAMINATION

*BRIEF RECOMMENDATION FOR EYE CARE AND TREATMENT; PROGNOSIS; REMARKS, RE: MENTAL COMPETENCE AND COOPERATION.

DO NOT WRITE BELOW THIS LINE

ACCORDING TO THE ABOVE OPHTHALMOLOGIC FINDINGS THIS EXAMINEE IS ☐ ELIGIBLE ☐ NOT ELIGIBLE

REMARKS:

COUNTY MEDICAL CONSULTANT