Report of Eye Examination

Association for the Blind
and Visually Impaired SC

Please send to Client Services via fax 843-577-4312 or email info@abvisc.org.

Patient Name: Date of Birth:

Patient Contact #: Date of Last Visit:

Medical Information

Primary Visual Diagnosis:

Best Corrected Visual Acuity: Right Eye Near Left Eye Near

Right Eye Distance Left Eye Distance

Visual Field (if known): Right Eye Left Eye

Glasses Prescribed: Yes ☐ No ☐

Is the patient deaf or hard of hearing? ☐ Unsure Yes ☐ No ☐

Please Certify the Following:

This patient has BCVA of 20/70 or worse and/or a visual field of 20 degrees or less in the better eye, or has a progressive condition that may cause such within the next two years: Yes ☐ No ☐

I am referring this patient to ABVI for
Low Vision Occupational Therapy/Vision Rehabilitation: Yes ☐ No ☐

Additional Notes/Impairments:

Referring Physician: Phone #:

☐ Ophthalmologist ☐ Optometrist ☐ Neurologist ☐ Other:

Name of Clinic: Fax #:

Physician's Signature: **Date:**

For all Low Vision Occupational Therapy services, the initial evaluation and plan of care will be sent to the referring doctor for review and approval signature.