Association for the Blind and Visually Impaired SC

Report of Eye Exam

Patient Information

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 Field	___________	Left Eye Field	___________

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
*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.

Additional Notes/Impairments:

____

Referring Physician Information

Referring Physician: ______________________________ **Name of Clinic:** ______________________________

Ophthalmologist Optometrist Neurologist Other:

Phone: ______________________________ **Fax:** ______________________________

Physician's Signature: ______________________________ **Date:** ______________________________

Please send this completed report to ABVI's Client Services via fax 843-577-4312, email info@abvisc.org, or mail to: ABVI, 1 Carriage Lane, Charleston, SC 29407.