

**THIS SECTION IS TO BE COMPLETED BY THE COUNSELOR**

Name  Last Name  First Name  Middle Initial

Date of Birth   -   -   Sex  Male  Female Case Number

Home Address  Number  Street

City  State  ZIP

Counselor Name  Last Name  First Name  Middle Initial

Counselor Address  Number  Street

City  State  ZIP

**THIS SECTION IS TO BE COMPLETED BY THE EXAMINING PHYSICIAN**

1. Visual Acuity	Distance	Without Correction		With Best Correction	
		Right	Left	Right	Left
	Near	Without Correction		With Best Correction	
		Right	Left	Right	Left

If necessary, state vision in terms of light perception, light projection, hand movements, or ability to count fingers.

- Visual Field Loss: (Complete visual fields chart on reverse or attach chart.)
- Primary Cause of Blindness: Right \_\_\_\_\_ Left \_\_\_\_\_
- Etiology: Right \_\_\_\_\_ Left \_\_\_\_\_ Inherited  Yes  No
- Prognosis:  Stable  Improving  Progressive  
Comment on Progressive Nature of Condition \_\_\_\_\_
- Medication or Treatment Recommended:  Yes  No (Explain "Yes" Response) \_\_\_\_\_
- Surgery Recommended:  Yes  No (Explain "Yes" Response) \_\_\_\_\_
- Low Vision Evaluation Recommended:  Yes  No (Explain "Yes" Response) \_\_\_\_\_
- Injury or Systematic Disease Related to Visual Loss:  Yes  No (Explain "Yes" Response) \_\_\_\_\_
- In view of the patient's eye diagnosis, treatment or surgery, indicate any restrictions (indicate the degree of restriction for each item checked):  
 None  Pushing  Bending  Lifting  Hauling  Prolonged reading or close work  Stretching  Stooping  
 Other (Specify) \_\_\_\_\_

Examining Physician  Please Print Name  Signature  X

Physician Address  Number  Street

City  State  ZIP  Date of Exam

**OTHER OBJECTIVE FINDINGS OF EXAMINATION MAY BE ATTACHED  
ADDITIONAL COMMENTS MAY BE MADE ON THE REVERSE SIDE OF THIS FORM**

