

# State of Texas Interagency Eye Examination Report

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
 Parent/Spouse Name: \_\_\_\_\_ Phone H: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_



## Attention Eye Care Specialist Starred Items indicate Required Information



Address **each** item below

*Your thoroughness in completing this report is essential for this patient to receive appropriate services*

### Ocular History (e.g., prematurity, previous eye diseases, injuries, or surgeries)

Age of Onset: \_\_\_\_\_ History: \_\_\_\_\_

### ★ Visual Acuity (VA)

If the acuity **can** be measured, complete this box using Snellen acuities or Snellen equivalents or NLP, LP, HM, or distance at which the patient sees the 20/200 letter.

Without Correction		With Best Correction	
Near	Distance	Near	Distance
R	R	R	R
L	L	L	L

### ★ \* IMPORTANT \*

If the acuity **cannot** be measured, enter X to select the most appropriate estimation.

- Legally Blind 20/200 or worse
- Between 20/70 and 20/199
- Better than 20/70
- Functions at the Definition of Blindness (e.g., CVI)

**Muscle Function:**  Normal  Abnormal Describe: \_\_\_\_\_

**Intraocular Pressure Reading:** R \_\_\_\_\_ L \_\_\_\_\_

### ★ Visual Field Test      Type of Field Test: \_\_\_\_\_ (Confrontation Not Acceptable)

- There is no apparent visual field restriction.
- There is a field restriction. Describe: \_\_\_\_\_

The field is restricted to:  21 to 30 degrees     20 degrees or less.

**Color Vision**  Normal  Abnormal

**Photophobia**  Yes  No

Type of test: \_\_\_\_\_

### ★ Diagnosis (Primary cause of visual loss):

\_\_\_\_\_

- ★ **Prognosis**     Permanent     Recurrent     Improving     Unable to determine prognosis at this time
- Progressive     Stable     Can be improved
- At risk for vision loss; this consumer is under 3 and/or the degree of vision loss cannot be determined.

**Treatment Recommended**

- Glasses    Prescription:    Right:    Left:
- Contacts    Prescription:    Right:    Left:
- Patches (Schedule):    Right:    Left:
- Clinical Low Vision Evaluation to determine:
- Medication:
- Surgery:
- Follow-up needed:
- Other:
- Return in:

**Precautions or Suggestions** (e.g., lighting conditions, activities to be avoided, etc.):

★ **IMPORTANT** ★ **Enter an X to select the most appropriate statement**

- This patient appears to have no vision     This patient does not have a serious visual loss after correction, in a clinical setting
- This patient appears to have a serious visual loss after correction, in a clinical setting     This patient has a diagnosis for a progressive medical condition that will result in no vision or a serious visual loss after correction

**X**

Print or Type Name of Licensed Ophthalmologist or Optometrist

Signature of Licensed Ophthalmologist or Optometrist

Address

Date of Examination

(    )

(    )

City

State

ZIP Code

Telephone Number

Fax Number

**RETURN COMPLETED FORM TO:**

Name: \_\_\_\_\_

Address

City

State

ZIP Code

(    )

(    )

Agency

Telephone Number

Fax Number

This form may be used when an ophthalmological/optometric examination is needed. It was revised by members of the Texas Education of Blind and Visually Impaired Students Advisory Committee. This form may be printed as needed. For additional copies, go to [http://www.dars.state.tx.us/dbs/manuals\\_forms.shtml](http://www.dars.state.tx.us/dbs/manuals_forms.shtml)