N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
VOCATIONAL REHABILITATION

LOW VISION EYE DOCTOR EVALUATION REPORT

Name ______________________ ______________________ __________
(Last) (First) (MI)

Background

Date of Birth ____________ Sex ________ Race ____________ County ____________

Address ____

Assessment Requested by ☐ Evaluation Unit ☐ Rehabilitation Center ☐ Field Staff

Reason for Referral: ____

____

Individual Goals/ Complaints: ____

____

____

____

Previous Health History

Primary eye condition ____

____

Secondary eye conditions ____

____

Relevant secondary health concerns ____

____

Eye Health Exam

Slit Lamp Exam

OD		OS
________	Lids	________
________	Lashes	________
________	Conjunctiva	________
________	Cornea	________
________	Iris	________
________	Lens	________

Fundus Exam

OD		OS
________	C/D	________
________	Rim	________
________	Vessels	________
________	Macula	________
________	Periphery	________

IOP

OD ________
OS ________
Time: ________

LOW VISION EYE DOCTOR EVALUATION REPORT

Contrast Sensitivity and Color Vision

Visual Acuity

Distance VA- sc or current Rx

OU ______________________

OD ______________________

OS ______________________

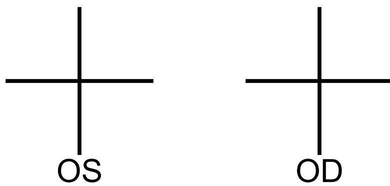
Near VA ___________________

Conditions which elicited best VA (lighting, EV, etc.)

** Visual acuities were obtained utilizing the best possible conditions for this individual and were not necessarily obtained under standardized conditions. Therefore, these acuities cannot be used to make a determination of legal blindness.*

Visual Fields

Confrontation



See attached reports

☐ Amsler Grid

☐ Tangent Screen

Refraction

Previous Refraction

	Sphere	Cylinder	Axis	ADD
OD				
OS				

Obtained from: ☐ Current eyeglasses ☐ Previous eye report

Current Refraction Distance

	Sphere	Cylinder	Axis		VA
OD				=	
OS				=	
ADD					

Current Refraction Near

	Sphere	Cylinder	Axis		VA
OD				=	
OS				=	

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Device Demonstrated	Visual Acuity	Accepted	Recommend	Comments

Recommended additional assessments/ instruction/ follow up

☐ Eccentric viewing training ☐ Filter evaluation ☐ Lighting assessment ☐ Reading stands

Comments and other recommendations

Low Vision Eye Doctor Signature and Title ____________________ Exam date __________

Distribution- Original: VR Counselor Copy: Unit Counselor, Low Vision Unit

N.C. Division of Services for the Blind
Name: ____________________