Columbia Regional Program

Autism Spectrum Disorders Services, Severe Orthopedic Impairment Services, Deafblind Services, Deaf/Hard of Hearing Services, Blind/Visually Impaired Services

833 N.E. 74th Ave., Portland, Or. 97213

Phone: (503) 916-5570 Fax: (503) 916-5576 Video Phone: 503-928-5858 Web Site: www.crporegon.org

VISION REPORT

(To be completed by an ophthalmologist or optometrist)

Child's Name _____ Birth Date _____

Address _____ City/State/Zip _____

To the Eye Care Specialist – Please address each item below.

Your thoroughness in completing this report is essential for this patient to receive appropriate educational services. Thank you for your time in providing this information.

Date of Examination: _____ Date of Report: _____

Diagnosis: _____

Etiology: _____

Prognosis: ❑ Stable ❑ Deteriorating ❑ Capable of Improvement ❑ Uncertain

Measurements

A. Visual Acuity

	Without Correction		With Correction	
	Distance	**Near**	**Distance**	**Near**
Right Eye (OD)				
Left Eye (OS)				
Both Eyes (OU)				

B. If visual acuity cannot be determined, please estimate visual functioning (indicate OD, OS, OU and methods of estimation)

	Reduced Visual Acuity	Counts Fingers	Hand Movement	Object Perception	Light Perception	NIL (Totally Blind)	Other (describe)
OD							
OS							
OU							

C. Method of estimation or instrument used: _____

D. Visual Field: Is there a limitation? ❑ Yes ❑ No ❑ Unable to determine

What is the widest diameter (degrees) of remaining visual field? Right Eye _____ Left Eye _____

Is there a preferred Field? ❑ Yes _____ ❑ No ❑ Unable to determine

E. Color Vision: ❑ Normal ❑ Impaired If impaired, what colors? _____

❑ Not tested Preferred colors? _____

F. Photophobia: ❑ Yes ❑No

G. Contrast sensitivity: _____

RECOMMENDATIONS

1. What medical treatment is recommended, if any? _____
2. Glasses: ❑ Not needed ❑To be worn constantly ❑Near only ❑Distance only
3. Would a low vision aid be helpful? ❑ Yes ❑ No Was one prescribed? ❑ Yes ❑ No

   Type: _____ Recommended Use: _____
4. Lighting requirements: ❑ Average ❑Better than average ❑ Avoid glare and overhead lights

   ❑ Other: _____
5. Physical activity: ❑Unrestricted ❑ Restricted –In what ways: _____

   _____
6. Date recommended for next examination: _____

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____

Address: _____ Phone: _____

City/State/Zip: _____

RETURN COMPLETED FORM TO:

_____ **Regional Program**

Contact Name
Address
City, State
Phone/Fax