



Texas Workforce Commission  
 Vocational Rehabilitation Services  
**Interagency Eye Examination Report**

**Patient Information**

Patient's name:		Date of birth:	
Address:		City:	State:    ZIP code:
Parent's or spouse's name:	Home phone: (    )	Cell phone (optional): (    )	Email address:

**Attention eye care specialist: Address each item below.**  
 Your thoroughness in completing this report is essential to this patient receiving appropriate services.

**Ocular History**

Age at onset:

Describe the ocular history, including eye diseases, injuries, or operations.

**Visual Acuity**

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

<b>Without correction:</b>	Near right:	Near left:	Distance right:	Distance left:
<b>With best correction:</b>	Near right:	Near left:	Distance right:	Distance left:

If the acuity cannot be measured, indicate below the most appropriate estimation.

- |  |   |
|--|---|
| Legally blind 20/200 or worse  | Better than 20/70   |
| Legally blind due to visual field of 20 degrees or less in both eyes | Functions at the definition of blindness (for example, CVI) |
| Between 20/70 and 20/199   |   |

**Muscle Function and Intraocular Pressure**

Muscle function:    Normal    Abnormal

Describe:

Intraocular pressure reading:                      Right:                      Left:

**Visual Field Test**

Type of field test:  
 (Confrontation is not acceptable. Attach a copy of the test.)



Precautions or suggestions (for example, lighting conditions, activities to be avoided):

### Overview

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 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.

### Eye Care Specialist Information

Signature of licensed ophthalmologist or optometrist:

**X**

Print or type name of licensed ophthalmologist or optometrist:

Address:

Date of examination:

City:

State:

ZIP code:

Telephone number:

( )

### Return completed form to:

Name:

Address:

Agency:

Texas Workforce Commission

City:

State:

TX

ZIP code:

This form should be used when an ophthalmological or optometric examination is conducted. It was developed by members of the Texas Education of Blind and Visually Impaired Students Advisory Committee, which consists of representatives from the following organizations: Texas Education Agency, Texas Workforce Commission Vocational Rehabilitation Services, Texas School for the Blind and Visually Impaired, Regional Education Service Centers, Texas Tech University, Stephen F. Austin University, Local School Programs, Deaf-Blind Multihandicapped Association of Texas, Texas Association of Parents of Children with Visual Impairments, Texas Association of Blind Students, National Federation of the Blind, American Foundation for the Blind, and Alliance of and for Visually Impaired Texans.