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|  | | | | | **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. | | | | | | | | | | | | | | | | | | | | | | |
| **Without correction**: | | Near right: | | | | Near left: | | | | | | | | Distance right: | | | | | | Distance left: | | |
| **With best correction**: | | 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  Legally blind due to visual field of 20 degrees or less in both eyes  Between 20/70 and 20/199 | | | | | | | | | Better than 20/70  Functions at the definition of blindness (for example, CVI) | | | | | | | | | | | | | |
| **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.) | | | | | | | | | | | | | | | | | | | | | | |
| No apparent visual field restriction exists.  A visual field restriction exists  Describe the restriction: | | | | | | | | | | | | | | | | | | | | | | |
| The visual field is restricted to:  21 degrees to 30 degrees  OD (right eye)  OS (left eye)  OU (both eyes) | | | | | | | | | | 20 degrees or less  OD (right eye)  OS (left eye)  OU (both eyes) | | | | | | | | | | | | |
| **Color Vision and Photophobia** | | | | | | | | | | | | | | | | | | | | | | |
| Normal  Abnormal | | | | | | | | | | | | | | | Photophobia:  Yes  No | | | | | | | |
| Type of test. Attach a copy of the test. | | | | | | | | | | | | | | | | | | | | | | |
| **Diagnosis** | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis (primary cause of visual loss):  ICD 10 code:      \_\_\_\_\_\_\_\_\_\_\_\_\_  ICD 10 code:      \_\_\_\_\_\_\_\_\_\_\_\_\_  Summarize the diagnosis. | | | | | | | | | | | | | | | | | | | | | | |
| **Prognosis** | | | | | | | | | | | | | | | | | | | | | | |
| Permanent | | | | | Recurrent | | | | | | | | | | | Improving | | | | | | |
| Progressive | | | | | Stable | | | | | | | | | | | Can be improved | | | | | | |
| Unable to determine prognosis at this time. | | | | | | | | | | | | | | | | | | | | | | |
| At risk for vision loss; this customer is under the age of 3 and/or the degree of vision loss cannot be determined. | | | | | | | | | | | | | | | | | | | | | | |
| **Treatment Recommended** | | | | | | | | | | | | | | | | | | | | | | |
| Select all that apply. | | | | | | | | | | | | | | | | | | | | | | |
| Glasses | | | Prescription: Right:       Left: | | | | | | | | | | | | | | | | | | | |
| Contacts | | | Prescription: Right:       Left: | | | | | | | | | | | | | | | | | | | |
| Patches | | | Right:       Left: | | | | | | | | | | | | | | | | | | | |
| Clinical low vision evaluation to determine: | | | | | | | | | | | | | | | | | | | | | | |
| Medication: | | | | | | | | | | | | | | | | | | | | | | |
| Surgery | | | | | | | | | | | | | | | | | | | | | | |
| Follow-up needed: | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | | | | | | | | | | | |
| Return in: | | | | | | | | | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | | | | | | | | | | |