Macomb Intermediate School District - Support and Related Services
Auxiliary and Preschool Services Center

37623 Garfield Road • Suite 110 • Clinton Twp. • MI • 48036 **Phone: (586) 412-2600 • Fax: (586) 412-8419**

EYE REPORT for CHILDREN with VISUAL IMPAIRMENTS

Please Return To _____

Name of Child _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

School District _____ School _____ Grade _____

ATTENTION Eye Care Specialist - Please address each item below. ATTENTION
Your thoroughness in completing this report is essential for this patient to receive appropriate services .

DATE OF EXAMINATION _____

OCULAR HISTORY (e.g., previous eye diseases, injuries, or operations)

Age of onset _____ History _____

VISUAL ACUITY

If the acuity can be measured, complete this box using Snellen acuities or Snellen equivalents or NLP, LP, HM, CF.

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

Acuity with glare testing, if applicable: **R** _____ **L** _____

If acuity **cannot** be measured, please check the most appropriate statement.

- ☐ This patient does not have a serious visual loss after correction.
- ☐ This patient has a visual loss after correction of **20/70** or less in the better eye.
- ☐ This patient has a serious visual loss after correction of **20/200** or less in the better eye.
- ☐ This patient appears to have no vision.

MUSCLE FUNCTION ☐ Normal ☐ Abnormal

Describe _____

INTRAOCULAR PRESSURE READING **R** _____ **L** _____

VISUAL FIELD TEST Describe

- ☐ There is no apparent visual field restriction.
- ☐ There Is a field restriction. (Please attach a copy of the test)

_____

The visual field is restricted to 20 degrees or less. ☐ Yes ☐ No

COLOR VISION ☐ Normal ☐ Abnormal **PHOTOPHOBIA** ☐ Normal ☐ Abnormal **STEREOPSIS** ☐ Normal ☐ Abnormal

CAUSE OF BLINDNESS OR VISION IMPAIRMENT: Present ocular condition(s) responsible for vision impairment.

O.D. _____

O.S. _____

Ocular Defects: ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Muscular ☐ Other _____

Cortical Visual Impairment: ☐ Yes ☐ No ☐ Possible

PROGNOSIS AND RECOMMENDATIONS: Is pupil's vision impairment considered to be:

☐ Stable ☐ Permanent ☐ Deteriorating ☐ Capable of Improving ☐ Uncertain

Treatment recommended _____

☐ Glasses ☐ Patches (Schedule): **R** _____ **L** _____

PHYSICAL ACTIVITY ☐ Unrestricted ☐ Restricted, as follows: _____

ADDITIONAL REMARKS _____

Date _____ Signed _____ Phone _____ FAX _____

Address _____ City _____ State _____ Zip _____