

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

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## 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.

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

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

- 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.

Acuity with glare testing, if applicable: R \_\_\_\_\_ L \_\_\_\_\_

**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 \_\_\_\_\_