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