VISION FOLLOW-UP REPORT FORM

Patient Name:____ Date of Exam:____________________________________

Ophthalmologist/Optometrist Name Printed:____

I. Far Vision, Left Eye (Uncorrected)_______
Far Vision, Right Eye (Uncorrected)_______
Far Vision, Both Eyes (Uncorrected)_______

Near Vision, Both Eyes(Uncorrected)_______

Are glasses or contacts recommended? Yes____ No____

II. Best Corrected Vision in Snellen Equivalents
Far Vision, Left Eye (With Correction)_______
Far Vision, Right (With Correction)_______
Far Vision, Both Eyes (With Correction)_______

Near Vision, Both Eyes(With Correction)_______

III. Were there conditions observed that would affect educational testing and/or programming? Yes____ No____
If yes, please explain the conditions that should be taken into consideration:

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IV. Does this patient have visual problems that are so severe that it would adversely affect his/her educational performance? If so, please describe the visual problem and how it would affect educational performance:

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V. Recommendations and/or comments related to this patient's vision:

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VI. If this patient cannot be conditioned for evaluation, please list the quantitative description of his/her vision and comments about any particular vision problems. Also, if this patient cannot be conditioned for evaluation and glasses are prescribed/worn, indicate the reason:

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Date:____________________ Signature of Ophthalmologist/Optometrist:____