Attention Eye Care Specialist
Address each item below.
Your thoroughness in completing this report is essential for this patient to receive appropriate services.

Ocular History (e.g. previous eye diseases, injuries, or operations)
Age of onset 7 years History Born with congenital cataracts. Removed at 9 months old. IOL placed.

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

<table>
<thead>
<tr>
<th>Without glasses</th>
<th>With Best Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near R 20/50 L 20/50</td>
<td>Distance R 20/80 L 20/80</td>
</tr>
</tbody>
</table>

Acuity with glare testing, if applicable: R _______ L _______

Muscle Function
- Normal
- Abnormal
Describe __

Intraocular Pressure Reading
R 16 L 18

Visual field Test
- There is no apparent visual field restriction.
- There is visual field restriction. Describe slight peripheral OU
- Yes
- No
The visual field is restricted to 20 degrees or less.

Color Vision
- Normal
- Abnormal

Photophobia
- Yes
- No

Diagnosis (Primary cause of visual loss)
Aphakia
Prognosis

- Permanent
- Progressive
- Recurrent
- Communicable
- Improving
- Can be improved

Treatment Recommended

- Glasses
- Surgery
- Patches (Schedule):
- Hospitalization will be needed for approximately ____________ days.
- Name of hospital ________________________
- Medication ____________________
- Refer for other medical treatment/exam:
- Name of anesthesiologist or group: __________________________
- Low Vision Evaluation
- Other __________________________

Precautions or Suggestions (e.g., lighting conditions, activities to be avoided, etc.)

Scheduling

Date of Next Appointment ________________ Time ____________________

IMPORTANT

☐ This patient appears to have no vision.
☐ This patient has a serious visual loss after correction.
☐ This patient does not have a serious visual loss after correction.

Print or Type Name of Licensed Ophthalmologist or Optometrist __________________________
Signature of Licensed Ophthalmologist or Optometrist __________________________
Address __________________________
Date of Examination __________________________
City __________________________ State __________________________ Zip __________________________
Telephone Number __________________________

RETURN COMPLETED FORM TO:
Name __________________________
Address __________________________
Agency __________________________ City __________________________ State __________________________ Zip __________________________