

**OCULAR REPORT / INFORME OCULAR**

NAME / NOMBRE	SEX / SEXO	DATE OF BIRTH / FECHA DE NACIMIENTO
ADDRESS (Street, City, Zip Code) / DIRECCIÓN (Calle, Ciudad, Código Postal)	PARENT OR GUARDIAN / PADRE O TUTOR	PHONE / TELÉFONO
ATTENDANCE SCHOOL DISTRICT (Name and Number) / DISTRITO ESCOLAR DE ASISTENCIA (Nombre y Número)	RESIDENT SCHOOL DISTRICT (Name and Number) / DISTRITO ESCOLAR DE RESIDENCIA (Nombre y Número)	GRADE / GRADO

**OVERALL DIAGNOSIS/ETIOLOGY**

RE/ \_\_\_\_\_

LE/ \_\_\_\_\_

**Does the child have a cerebral/cortical visual impairment?**     Yes     No     Suspect

***FILL IN BOTH DISTANT AND NEAR VISION***

DISTANT VISION			NEAR VISION		PRESCRIPTION			
VISUAL ACUITY	Without Correction	With Best Spectacle Correction	Without Correction	With Best Spectacle Correction	SPH.	CYL.	AXIS	ADD
Right Eye								
Left Eye								
Both Eyes								
Testing Instrument Used					Date of Above RX			

**FUNCTIONALLY BLIND:** In examiner’s opinion, acuity cannot be measured, and student presents as functionally blind. Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment (e.g., brain injury or dysfunction).

Yes     No

**VISION PROGNOSIS**

Student’s vision impairment is considered to be:

Stable     Capable of Improvement     Progressing     Fluctuating     Uncertain

**VISUAL FIELD RESTRICTION?**     Yes     No

If yes, widest remaining visual field (in degrees)    RIGHT \_\_\_\_\_    LEFT \_\_\_\_\_

Significant Field Restriction (please describe) \_\_\_\_\_

**IMPAIRED COLOR PERCEPTION?**     Yes     No    Which colors? \_\_\_\_\_

Student's Name: \_\_\_\_\_

**TREATMENT RECOMMENDED**

Medication (List): \_\_\_\_\_

Surgery (Describe): \_\_\_\_\_

Glasses       Contact Lenses

Constant Wear       Near Vision Only       Far Vision Only

Occlusion

RE \_\_\_\_\_ LE \_\_\_\_\_ Type of Occlusion \_\_\_\_\_ Amount of time per day \_\_\_\_\_ Duration of Treatment \_\_\_\_\_

Low Vision Aid Prescribed:

Distant: Type \_\_\_\_\_ RE \_\_\_\_\_ LE \_\_\_\_\_

Near: Type \_\_\_\_\_ RE \_\_\_\_\_ LE \_\_\_\_\_

Lighting Requirements

Average       Other \_\_\_\_\_

Restricted Physical/Recreational Activities

No Restrictions       Specify Restrictions: \_\_\_\_\_

**RE-EXAMINATION ADVISED**

Six Months       Twelve Months       Other \_\_\_\_\_

**TYPE OF EXAMINER / TIPO DE EXAMINADOR**

- Ophthalmologist / Oftalmólogo       Optometrist / Optometrista       EENT / Doctor de Ojos, Oídos, Nariz y Garganta  
 Other M.D. (specify) / Otro Doctor en Medicina (especifique)

\_\_\_\_\_  
Name of Examiner / Nombre del Examinador

\_\_\_\_\_  
Date of Examination / Fecha del Examen

\_\_\_\_\_  
Street Address / Dirección

\_\_\_\_\_  
City, State / Ciudad, Estado

\_\_\_\_\_  
Zip / Código Postal

\_\_\_\_\_  
PHONE / TELÉFONO

\_\_\_\_\_  
*Signature of Examiner / Firma del Examinador*

\_\_\_\_\_  
*Date / Fecha*

**I give permission for this ocular report to be released to / Doy permiso para que este informe ocular se entregue a:**

\_\_\_\_\_  
Name of District/Coop/Agency/Organization / Nombre del Distrito/Cooperativa/Agencia/Organización

\_\_\_\_\_  
Attention to / Atención a:

\_\_\_\_\_  
Street Address / Dirección

\_\_\_\_\_  
City, State / Ciudad, Estado

\_\_\_\_\_  
Zip / Código Postal

\_\_\_\_\_  
Email / Correo Electrónico

\_\_\_\_\_  
Fax

\_\_\_\_\_  
*Signature of Parent / Firma del Padre*

\_\_\_\_\_  
*Date / Fecha*