GREATER DETROIT AGENCY FOR THE BLIND AND VISUALLY IMPAIRED
Information Release Authorization and Vision Examination Report

PLEASE RETURN THIS FORM TO GDABVI AT 313.272.6893 (fax) or SERVICEFORMS@GDABVI.ORG
Phone: 313.272.3900 Fax: 313.272-6893 Online form: lifebeyondsight.org/visionreport

PLEASE PRINT

Individuals must provide this form in order to receive services from the Greater Detroit Agency for the Blind and Visually Impaired ("GDABVI"). This proof of examination must be completed by a licensed optometrist, ophthalmologist, or physician who provides complete eye examinations and signed by the client (or their legal representative) and the examiner. The exam must be completed within one year prior to this request.

Client's Name ↑: (Last, First, MI) (Date of birth)

Address: (Number and Street) (City / State / Zip) (County)

Phone: **Email:**

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Transgender ☐ Other ☐ Prefer not to disclose

I agree to release the information contained in this report to GDABVI to develop a rehabilitation plan and other services. This information will remain confidential and will not be distributed to unauthorized parties.

X

Client or legal representative signature **Date**

↑ Print name of legal representative **Phone**

VISION EXAMINATION REPORT – TO BE COMPLETED BY EXAMINING DOCTOR

History

A. Age at onset of significant visual defect: Right Eye (O.D.) Left Eye (O.S.)

B. Etiology (injuries, infections, surgeries, hereditary factors):

Visual Acuity

	Distance vision			Near vision		
	Without correction	Best correction	Without correction	Without correction	Current correction	Best correction
OD (Right)						
OS (Left)						
OU (Both)						

Intraocular pressure in mm. hg. *(Specify instrument)*: Right Eye (O.D.) _____ Left Eye (O.S.) _____

Using ICD Codes from the World Health Organization definitions, vision impairment status is rated as moderate, severe, profound, nearly total, and total:
Vision impairment status code: Right Eye (O.D.) _____ Left Eye (O.S.) _____

Visual Fields

If there is a limitation, please attach a copy of the most recent visual field test.

Describe: ☐ Central ☐ Peripheral
A visual field of: ☐ 21 to 30 degrees ☐ 20 degrees or less ☐ Unable to determine
☐ No apparent field loss ☐ Other (Please describe) _____

Is this person legally blind? ☐ Yes ☐ No

Diagnosis (primary eye condition, including condition responsible for vision impairment):
Right eye: _____
Left eye: _____

Indicate at least one of the following criteria that best describes the patient's visual functioning:

☐ Visual acuity of 20/70 after best possible correction
☐ A peripheral field so constricted that it affects the patient's ability to function in an educational or workplace setting
☐ A diagnosis of visual impairment after best correction
☐ A progressive loss of vision that may affect the patient's ability to function in an educational or workplace setting

Prognosis and recommendations

A. Patient's vision is considered: ☐ Stable ☐ Uncertain ☐ Capable of improvement ☐ Deteriorating

B. Recommended treatment:

C. Recommended vision rehabilitation training:

D. Other disabilities:

Referring physician name: _____ Phone: _____

Address: _____

Examiner's name (printed): _____ Phone: _____

Address: _____

Examiner's signature: X _____ Date: _____