Guiding Eyes for the Blind
Vision Assessment Form
(To be completed by eye care professional)

THIS FORM DOES NOT NEED TO BE COMPLETED IF YOU ARE A RETURNING GRADUATE

Patient’s Name: ____________________________________________________________

Date of Most Recent Exam: __________________________________________________

Cause of Vision Loss: ______________________________________________________

When did vision loss occur?  □ Birth  □ Juvenile  □ Adolescent  □ Adult

If multiple occurrences or causes, please explain:

________________________________________________________________________

Acuity: _________  Field vision: _________

Please choose the best description of the client’s visual status:

R eye- □ None  □ High partial  □ Low partial  □ Shadows  □ Hand motion @ ___ ft.  □ Light perception
□ Other: _________________________

L eye- □ None  □ High partial  □ Low partial  □ Shadows  □ Hand motion @ ___ ft.  □ Light perception
□ Other: _________________________

Prognosis: _______________________________________________________________

Is client legally blind?  □ Yes  □ No

Ocular medications: _________________________________________________________

COMMENTS:

Signature: _________________________________________________________________

M.D./D.O./O.D. Address: ___________________________________________________

(Please type or print name)

Date: ________________

Telephone No. __________________________

Fax No. ________________________________