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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: _____

Patient's Date of Birth: _____ 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. _____