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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: _____

_____
(Please type or print name)

Date: _____

M.D./D.O./O.D. Address: _____

_____

_____

Telephone No. _____

Fax No. _____