HAROLD LEWIS CENTER

1280 Charles Lane
Marysville, Ohio 43040
Phone (937) 645-6714 Fax (937) 642-9909

VISION EXAMINATION REPORT FORM 2017-2018

Child's Name: _____ Date of Birth: _____

Vision Concerns / Diagnoses: _____

_____

Is this child Visually Impaired? _____ Yes _____ No _____ Unsure

Visual Acuities: Please record whatever acuities are available. If numerical acuity data are not available, please indicate best estimates (e.g., NLP, LP, LProj., HM, Fixes & Follows, CSM or "suspect significant vision problem", etc).

_____

	Without Correction		With Correction	
	Distance	Near	Distance	Near
Right Eye	_____	_____	_____	_____
Left Eye	_____	_____	_____	_____
Both Eyes	_____	_____	_____	_____

Test(s) conducted: _____ PLT _____ HOTV _____ Snellen _____VER/VEP Other: _____

Refractive Error: RE: _____ LE: _____

Eyes in Alignment? Yes No Comments: _____

Color Vision Normal? Yes No Comments: _____

Visual Fields Full? Yes No Comments: _____

Suspect Visual Processing Difficulties? Yes No Comments: _____

Condition is: _____ Stable _____ Progressive _____ Fluctuating _____ Uncertain _____ Capable of Improving

Recommendations for Medical Care and Education: _____

_____

Visual Aids Prescribed/Recommended: _____

Last Exam Date: _____ When do you want to see this child again? _____

_____ _____

Examiner's Signature Examiner's Name and Title (Please Print or Type)

_____ _____

Date Address

_____ _____

Phone Number City, State, Zip Code