COLUMBIA REGIONAL
INCLUSIVE SERVICES
833 NE 74th Avenue, Portland OR 97213
503.916.5570 503.916.5576 crisoregon.org

VISION REPORT

(To be completed by an ophthalmologist or optometrist)

Child's Name _____ Birth Date _____

Address _____ City/State/Zip _____

To the Eye Care Specialist—Please address each item below.

Your thoroughness in completing this report is essential for this patient to receive appropriate educational services. Thank you for your time in providing this information.

Date of Examination: _____ Date of Report: _____

Diagnosis: _____

Etiology: _____

Prognosis: ☐ Stable ☐ Deteriorating ☐ Capable of Improvement ☐ Uncertain

Measurements

A. Visual Acuity

	Without Correction		With Correction	
	Distance	**Near**	**Distance**	**Near**
Right Eye (OD)				
Left Eye (OS)				
Both Eyes (OU)				

B. If visual acuity cannot be determined, please estimate visual functioning.

	Reduced Visual Acuity	Counts Fingers	Hand Movement	Object Perception	Light Perception	NIL (Totally Blind)	Other (describe)
OD							
OS							
OU							

C. Method of estimation or instrument used: _____

Our Services: Autism, Blind/Visually Impaired, Deaf/Hard of Hearing, Deafblind, Orthopedic Impairment, Traumatic Brain Injury

D. Visual Field: Is there a limitation? ☐ Yes ☐ No ☐ Unable to determine

What is the widest diameter (degrees) of remaining visual field? Right eye _____ Left eye ____

Is there a preferred field? ☐ Yes _____ ☐ No ☐ Unable to determine

E. Color Vision: ☐ Normal ☐ Impaired ☐ Not tested

If impaired, what colors? _____

Preferred colors: _____

F. Photophobia: ☐ Yes ☐ No

G. Contrast sensitivity: _____

RECOMMENDATIONS

1. What medical treatment is recommended, if any? _____
2. Glasses: ☐ Not needed ☐ To be worn constantly ☐ Near only ☐ Distance only
3. Would a low vision aid be helpful? ☐ Yes ☐ No Was one prescribed? ☐ Yes ☐ No

   Type: _____ Recommended use: _____

4. Lighting requirements: ☐ Average ☐ Better than average ☐ Avoid glare and overhead lights

   ☐ Other _____
5. Physical activity: ☐ Unrestricted ☐Restricted—In what ways: _____

   _____
6. Date recommended for next examination: _____

Physician's Signature _____ Date: _____

Physician's Name (Please Print) _____

Address: _____ Phone: _____

City/State/Zip: _____

RETURN COMPLETED FORM TO:

Columbia Regional Inclusive Services

Attn: _____

833 NE 74th Ave.

Portland, OR 97213

Fax: 503-916-5576