

	Sphere	Cylinder	Axis	Corrected Near Visual Acuity	Corrected Distance Visual Acuity
Right Eye (OD)					
Left Eye (OS)					

F. Is visual field normal? YES NO If no, please attach or describe: _____

G. Is there normal color perception? YES NO
 If no, what color(s)? _____
 Please indicate test used: _____

H. Is there evidence of light sensitivity? YES NO

III. PROGNOSIS AND RECOMMENDATIONS

A. Recommendations:

- Low vision examination Glasses
 Optical aids Other _____

Comments: _____

B. Preferred lighting: _____

C. Special tinted lenses/filters recommended? YES NO
 Specify: _____

D. Specify need for physical restrictions: _____

E. Reading Model(s):

- Large Print CCTV
 Standard Print Braille
 Tape

F. Prognosis: Stable Deteriorating Capable of Improvement

Comments: _____

Wish to see child again? YES NO
 If yes, when? _____

Doctor's Name (Signature): _____

Doctor's Name (Print): _____

Address: _____

(No. and Street)

(City or Town)

(County)

(State)

(Zip)

Phone: _____

Return to: Cleveland Sight Center, Children & Young Adult Services

1909 E. 101 St., Cleveland, OH 44106