Low Vision Evaluation

Patient: ___________________________ DOB: ___________ Examination Date _______

History:

Impairment due to?

Goals:
1.
2.
3.

Acuity

Distance VA Test? ____________________ Near VA Test?___________________

OD OS OD OS

Refraction

Retinoscopy	Subjective	
OD_____________________	OD _____________________	VA
OS _____________________	OS _____________________	VA

Near Assessment

High add:

Hand-held mags:

Near telescopes:

Video magnifier:

Computer/tablet/software:

Distance Assessment

Monocular telescope:

Binocular telescope:

Glare, lighting & filters, daily living aids

Treatment Plan

1.
2.
3.
4.
5.

Dr. Signature: ____________________________. Date _________________ Time Spent _______