

**West Virginia Department of Health and Human Resources
OPTOMETRIST'S REPORT**

MA ID No./Pending Medicaid No.: _____

Patient's Name _____
Street Address _____ City and State _____
Date of Birth _____ Sex _____ Race _____ Age at onset of blindness _____

Ocular Motility

Nerve Heads (describe nerve heads and vessels emerging from nerve heads)

Status of Corneal: Clear Cloudy

	Without glasses		With glasses	
	Distance (20 Ft.)	Near (14 in.)	Distance (20 ft.)	Near (14 in.)
Right eye	_____	_____	_____	_____
Left eye	_____	_____	_____	_____

Peripheral Vision with Hand Motion O.D. O.S.

Peripheral Vision (See Note 2)

Is there any limitation in the field of vision? _____ If so, indicate the best vision obtainable for each quadrant, by small spot light or test object.

Please indicate size. _____

Opinion as to whether visual acuity might be improved:

By glasses: _____

By other means: _____

Remarks: _____

Date of examination: _____

(Signature of Optometrist)

Date of Report: _____

(Address)

NOTE 1. Measurements will be assumed to be stated in the Snellen formula (either feet or inches) unless otherwise noted. If exact measurements of central vision cannot be given, describe the test used so as to indicate the distance and the size of the test object. Examples: Count fingers at three feet; hand movement at three feet; light perception only.

NOTE 2. Tests should be made with patient fixing one eye on a point three feet straight ahead and with objects held at a distance of three feet from the fixation point in the quadrant of the field under examination, the other eye to be kept closed or covered.

Please use reverse side for recording re-examinations, operations, treatment, etc.

HISTORY OF EYE INJURY

Name: _____ Date of accident: _____

Address: _____ Which eye was injured? _____

1. Age when accident occurred: _____
2. What was the nature of the accident; was there a perforating injury; was the eye cut?
Describe in detail. _____

3. What was the individual doing when the injury occurred; cutting with scissors; using knife, hammering, filing, chopping wood, etc.? If an automobile accident, state whether injury was from broken glass, splinters, a blow:
Describe in detail: _____

4. Was any operation performed? _____
5. Was there any sight remaining in the injured eye after the accident? _____
6. When did the injured eye become blind? _____
7. If the injured eye was totally blind, did the doctor advise removing it? _____
8. Was the injured eye, if sightless, removed? _____ Date _____

HISTORY OF THE GOOD EYE

1. How soon did the sight in the good eye begin to disappear? _____
2. How soon after it became affected, was an eye specialist consulted? _____
3. What was his advice? _____
4. When did the good eye become blind? _____

Please give any further details in connection with the accident: _____

Date of Report _____ Optometrist _____

RE-EXAMINATIONS

Date	Best Corrected Vision		Changes in Eye Condition	Recommendations (Further examination or treatment - specify)	Optometrist's Signature
	Right Eye	Left Eye			