Colorado Low Vision Evaluation Clinics

Attention Eye Care Specialist

The following mentioned child is scheduled to receive a functional low vision evaluation sponsored by the Colorado Department of Education Low Vision Evaluation Clinic team. Your thoroughness in completing this report is essential in the process of providing the most appropriate services for this child. This team does not provide any eye health care. Therefore, the patient will be referred back to your office for continued eye health management. Thank you!

Thomas W. Theune, OD, Low Vision Specialist

Patient Information and Ocular History

Patient's Name: _____
D.O.B. _____ / _____/ _____ Male:_____ Female:_____

Phone: (_____)_____

Address:_____

_____

City: _____ State: _____Zip: _____

Date of Last Evaluation: _____ / _____ / _____

Diagnosis: _____
_____

Age of Onset: _____

Prescriptions & Acuities

	Habitual Rx (wearing)			Distance Acuity		
	Sph	Cyl	Axis		Add	Prism
OD				20/		
OS				20/		

	Most Recent Rx			Distance Acuity		
	Sph	Cyl	Axis		Add	Prism
OD				20/		
OS				20/		

If the acuity **cannot** be measured, check the most appropriate **estimation**:

- ❑ The best corrected vision is 20/70 or worse in the better eye.
- ❑ The best corrected vision is 20/200 or worse in the better eye (legally blind)

***Patient Name: _____

Ocular Motility

- ❑ **Normal**
- ❑ **Abnormal** If abnormal, please describe:

_____

_____

Visual Field

- ❑ **Normal**
- ❑ **Abnormal**
  - ➢ If so, is the visual field restricted to 20 degrees or less? _____Yes _____No
  - ➢ If abnormal, please describe or **send a copy of latest field**:

_____

_____

Prognosis and Treatment Recommendation(s)

- ❑ Stable **Comments:**_____
- ❑ Progressive _____
- ❑ Recurrent _____

Treatment Recommendations:

_____

_____

Recommended Date to return to your office? _____

Precautions or Physical Restrictions:

- ❑ None

If yes, please note your recommendations:

_____

_____

Treating Eye Care Professional

Name:_____

Address:_____

_____

City _____State _____ Zip_____

Phone: (_____) _____FAX: (_____) _____

Signature: _____Date: _____

Please mail or FAX this completed form to:

***School District Personnel: Please populate your contact information below before sending this form to your student's eye care specialist.

School District Name: _____

Attention: (TVI's name): _____

Address: _____

City, State, Zip Code: _____

Phone: (_____) _____-_____ FAX: (_____) _____-_____

If you have any questions about the form and/or the low vision clinics, please call Dr. Tom Theune at (719) 471-3200.