

Patient's name		Insured ID (Prime Number)	
SSN		Date of birth	
Agency Use Only – Complete fully before routing			
Program	Branch	Case Number	Worker ID
Case Name		Date of request	

Report on Eye Examination

Legal blindness

To meet the criteria of legal blindness, the answer must be “Yes” to one of the following four questions:

- | | | |
|---|------------------------------|-----------------------------|
| 1. Is the impairment of central visual acuity in the better eye after best correction to 20/200 or less? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Is the contraction of peripheral visual fields in the better eye to 10 degrees or less from the point of fixation; or | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Is the contraction of peripheral visual fields in the better eye so the widest diameter subtends an angle no greater than 20 degrees; or | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Is the contraction of peripheral visual fields in the better eye to 20 percent or less visual field efficiency? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Diagnosis, prognosis and treatment

Diagnosis	Prognosis
Is the condition progressive? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the expected duration of the condition? <i>(select one)</i> <input type="checkbox"/> Less than 60 days <input type="checkbox"/> 60 days or longer
Will the condition deteriorate without treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is treatment indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No
If treatment is indicated, please describe any recommended treatment:	

Examiner signature

Examiner's name: _____ Phone number: _____
(please print or type)

Address: _____ Fax number: _____

Signature

Date of examination