SIGHT FOR LIFE

OPHTHALMOLOGIC EVALUATION

Patient Name:____

DOB:____________

I hereby authorize and instruct the examining physician to release any medical information to the Sight for Life Foundation by completing and returning this form to the Foundation address given below.

SIGNED____
Client or Representative

DATE_________________

TO BE COMPLETED BY OPHTHALMOLOGIST:

BRIEF HISTORY:

PAST OCULAR HISTORY: (include trauma and surgeries)

VISUAL ACUITY:

	Uncorrected	Uncorrected	Corrected	Corrected
	Distance	Near	Distance	Near
Right Eye				
Left Eye				
Both Eyes				

INTRAOCULAR PRESSURES:

Right Eye ________mmHg

Left Eye ________mmHg

REFRACTION:

	Sphere	Cylinder	Axis	Prism	VA	Add
Right Eye						
Left Eye						

VISUAL FIELDS:

Do confrontational fields reveal any significant restrictions: **Yes____ No____**

If yes, describe or draw defects:

(attach fields, if performed)

PERTINENT OPHTHALMIC FINDINGS:

DIAGNOSIS:

IS THERE A REASONABLE LIKELIHOOD THAT VISION COULD BE RESTORED OR HELPED BY TREATMENT OR SURGERY: Yes___ No___

RECOMMENDATIONS & REMARKS:

TREATMENT: ______________________________
SURGERY: ________________________________
TRAINING: _________________________________
RESTRICTIONS: _____________________________
OTHER: ____________________________________

____
EXAMINING PHYSICIAN

____
DATE OF EXAM

Please return the completed Examination Form to:

SIGHT FOR LIFE FOUNDATION
10624 S. Eastern Avenue; Suite A #623
Henderson, NV 89052
FAX (702) 492-6978

FOR BOARD USE ONLY:

Board Decision: Accepted________ Declined_________

Board member signature_________________________ Date____________

Board member signature_________________________ Date____________