LOW VISION EVALUATION (LVE) REPORT

FOR STUDENTS IN GEORGIA SCHOOLS

Items with an asterisk (*) are considered the minimal components of a Clinical Low Vision Evaluation Report for educational purposes.

*BACKGROUND INFORMATION

Student's name _____ Date of evaluation _____

School system _____ DOB /age _____

Low vision clinic name _____ Low vision therapist (If attending) _____

Low vision optometrist/clinician's name _____

*MEDICAL HISTORY

Date of current medical eye examination _____

Name of clinician _____ Check one: ☐ MD ☐ OD

Reported ocular diagnosis from medical eye examination

_____

Previous LVE ☐ Yes ☐ No. If yes ,date. _____

***Please attach current medical eye report (Mandatory) and most recent LVE report (if applicable).**

Additional disabilities/medical problems:

_____

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*VISUAL ACUITIES:

	Distance (20' or less as determined by clinician)(Please indicate at what distance).		**Intermediate** (18"-36")(Please indicate at what distance).		**Near** (Up to 16")(Please indicate at what distance).	
	Without Correction	With Correction	Without Correction	With Correction	Without Correction	With correction
O.D.						
O.S.						
O.U.						

*Visual Fields: (Check one).

☐ Interpretation of formal visual fields testing from primary eye care physician by low vision optometrist:

Results:

OR

☐ Determination of confrontation visual fields by low vision optometrist:

Results:

COLOR VISION SCREENING (Check all that apply)

☐ Farnsworth D-15 ☐ Farnsworth D-15 jumbo ☐ Farnsworth D-15 matching

☐ Ishihara color plates ☐ Other color vision screening(Please specify)

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Results:

Refractive Evaluation

	Sphere	Cylinder	Axis	Prism	Add
Right eye (OD)					
Left eye (OS)					

*Binocularity (Check one)

☐ Binocular ☐ Monocular ☐ Bi-ocular (Each eye is working independent of the other one).

Preferred eye

*Contrast Sensitivity

Type of sensitivity:

Degree of sensitivity:

Illumination needs:

Glare issues:

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*Contrast Sensitivity (Continued)

Color/background contrast needs:

General impressions:

Concerns of student/family and recommendations:

Activity restrictions (if any):

Eye safety recommendations:

Additional evaluations/tests needed:

Devices recommended to access instruction in appropriate development sequence:

☐ **NEAR**

Optical:

Non-optical:

Electronic/software:

☐ **INTERMEDIATE**

Optical:

Non-optical:

Electronic/software:

☐ **DISTANCE**

Optical:

Non-optical:

Electronic/software:

Lighting and glare control:

Seating recommendations:

Recommendations for binocularity issues (if any):

Recommendations for use of devices for specific tasks needed to access instruction:

Recommendations for future low vision evaluations:

_____ _____

Low Vision Optometrist Signature Date of LVE

_____

Low Vision Therapist Signature

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