



## Visual Medical Certification

### I. Report of Examination

#### Distance:

<b>*Without glasses</b>	<b>*With Best Correction</b>	<b>*Percentage Loss with Rx:</b>
OD: _____	OD _____	OD _____
OS: _____	OS _____	OS _____

Observations: \_\_\_\_\_

#### Reading:

<b>*Without glasses</b>	<b>*With Best Correction</b>	<b>*Percentage Loss with Rx:</b>
OD: _____	OD _____	OD _____
OS: _____	OS _____	OS _____

Observations: \_\_\_\_\_

**Visual Field:** \_\_\_\_\_ **Normal** \_\_\_\_\_ **Restricted** \_\_\_\_\_

#### Binocular Function:

A) Does the patient have useful binocular vision in all directions with correction?

For distance: \_\_\_\_ Yes \_\_\_\_ No  
 For Near: \_\_\_\_ Yes \_\_\_\_ No

B) Is depth perception present? \_\_\_\_ Yes \_\_\_\_ No

C) Color perception: \_\_\_\_\_ Normal \_\_\_\_\_ Not normal

D) If color blind, which colors? \_\_\_\_\_

### II. Diagnosis

Eye pathology: \_\_\_\_\_

Primary condition: \_\_\_\_\_

Secondary condition: \_\_\_\_\_

Causes of condition: \_\_\_\_\_

Characteristics of condition: \_\_\_\_ Stable \_\_\_\_ Progressive \_\_\_\_ Improving

\_\_\_\_ Recurrent \_\_\_\_ Permanent \_\_\_\_ Other: specify \_\_\_\_\_



Prognosis: \_\_\_\_\_

Specify functional limitations:

\_\_\_\_\_

\_\_\_\_\_

### III. Recommendations

Treatment recommended:

\_\_\_\_\_

\_\_\_\_\_

If the treatment is surgical, please specify the expected outcome of procedure:

\_\_\_\_\_

\_\_\_\_\_

Specify academic reasonable accommodations:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other recommendations:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Nombre del(a) especialista

\_\_\_\_\_

Especialidad

\_\_\_\_\_

NPI

\_\_\_\_\_  
Firma del(la) especialista

\_\_\_\_\_

Número de licencia

\_\_\_\_\_

Fecha

\_\_\_\_\_  
Dirección y teléfonos de oficina