



**DELAWARE HEALTH AND SOCIAL SERVICES**

**DIVISION FOR THE VISUALLY IMPAIRED**

1901 N. Dupont Highway, Biggs Building  
New Castle, DE 19720  
Phone: (302) 255-9800  
Fax: (302) 255-9921

**EYE REPORT FORM**

Dear Doctor: In order for DVI to provide services to the patient noted below, we require the following information from you. *Please return the completed form to **DVI, Attention: DVI Intake**.* Thank you.

*Please type or print clearly.*

**PATIENT NAME** \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

**DIAGNOSIS** (*Eye Condition Primarily Responsible for Vision Impairment*)

**Right Eye** \_\_\_\_\_ **Left Eye** \_\_\_\_\_

**CENTRAL VISUAL ACUITY** *WITH CORRECTION (Distance at 20' )*

**Right Eye** \_\_\_\_\_ **Left Eye** \_\_\_\_\_

**FIELD LIMITATIONS**

**Type of Field Test** (*If Completed*) \_\_\_\_\_  
(*Please attach a copy of the field test.*)

**Right Eye** \_\_\_\_\_ **Left Eye** \_\_\_\_\_

**DATE OF MOST RECENT EYE EXAMINATION** \_\_\_\_\_

**VISUAL CATEGORY** (*Please select one of the following visual categories:*)

- Totally Blind** (*No Light Perception*)
- Legally Blind** (*20 / 200 visual acuity in the better eye with correction **OR**, has a field restriction of 20 degrees or less*)
- Severely Visually Impaired** (*20 / 70 visual acuity in the better eye with correction*)
- Visually Ineligible** (*The person **does not** match one of the above three categories*)

**EXAMINING PHYSICIAN** \_\_\_\_\_  
(*Printed*)

Date \_\_\_\_\_

\_\_\_\_\_  
(*Signature*)