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 Central Intake: (302) 255-9848

EYE REPORT FORM

(Please see instructions for completion on back of this page)

Dear Dr. _____ In order for DVI to provide the best service to the patient noted below, we request the following information from you. *Please return the completed form to* ***DVI, Attention: DVI Intake*** at the address or fax number above*.* 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 to 20/200 visual acuity in the* ***better*** *eye with correction)*
- ☐ ***Visually Ineligible*** *(The person* ***does not*** *match one of the above three categories)*

EXAMINING PHYSICIAN _____ Date _____
(Printed)

_____
(Signature)

We appreciate your cooperation in completely entering the information on the form. Accurate information allows us to provide better and more efficient service to your patients and our consumers. It also enables DVI to maintain an accurate Registry. If you have questions about the proper completion of this form, please contact central intake, **302-255-9848** or **302-424-8638**.

Instructions for Completing Form:

1. Please type or print clearly all the **Patient** Data information: (Correct spelling of name, current address and phone number, accurate birth date and social security number).

2. Include a diagnosis.

3. Include correct distance acuity for **each eye**.

4. If a **field test** was completed, include a copy of the test.
   Please also note the degree of the field loss.

5. If no field test was completed, please note **N/A** in the Field Limitations Section.

6. Include the **date of the examination.**

7. Check the appropriate visual category using the definitions provided. **Please note on the form** if the consumer is legally blind by a **field restriction** rather than by visual acuity.

8. Please be sure that the form is signed and dated by the **Examining Physician** along with his/her typed or printed name.

Thank you.