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## OPHTHALMOLOGIST / OPTOMETRIST REPORT

**Applicant:** This form must be completed by your Ophthalmologist or Optometrist.

**Physician:** Your patient has applied for a guide dog to enhance his/her mobility and independence. Although our school is located in a windy, desert environment, we do travel to many different locations within Southern California. Your information will help us provide your patient with the training and instruction most suited to their needs. Thank you for your assistance.

Applicant's name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Details of Blindness:** Is Applicant legally blind?  Yes  No Date of last examination: \_\_\_\_\_

<b>Cause of vision loss:</b>	<b>Primary</b>	<b>Secondary</b>
OD	_____	_____
OS	_____	_____

Is Applicant's vision loss considered to be:  
 Progressive \_\_\_\_\_ Stable \_\_\_\_\_ Likely to improve \_\_\_\_\_ Uncertain \_\_\_\_\_

In what year did blindness occur? \_\_\_\_\_ How long have you attended this patient? \_\_\_\_\_

Visual Acuity

With correction:	OD _____	OS _____	OU _____
Uncorrected:	OD _____	OS _____	OU _____

Visual Fields

Central:	OD _____	OS _____	OU _____
Peripheral:	OD _____	OS _____	OU _____

Please describe residual vision:

No light perception	Some light perception	Gross movement	Count fingers	Read with lens
OD _____	_____	_____	_____	_____
OS _____	_____	_____	_____	_____

Please list any ocular medications: \_\_\_\_\_

Comments: \_\_\_\_\_

**Date of exam on which report is based:** \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**

Doctor's name: \_\_\_\_\_  
*Please print*

Telephone: (\_\_\_\_) \_\_\_\_\_



Hospital / Clinic Stamp