Gallant Heart Guide Dog Center
Ophthalmology
Report

...it takes a gallant heart...

This report is to be completed by either an Ophthalmologist or Optometrist and is essential to this patient receiving appropriate service.

Date of Exam: _____

Patient Name: _____ *Date of Birth:* _____

Address: _____
Street *City* *State* *Zip*

Cause of Blindness

Age of Onset: _____

Hereditary: _____ *Age Related:* _____ *Other:* _____

Congenital: _____ *Systemic Disease:* _____

Visual Acuity

If the acuity can be measured, complete the section below using Snellen acuities, Snellen equivalent, or NLP, LP, HM, CF

	Near Vision		*Distant Vision*	
Visual Acuity	***Without Correction***	***With Best Correction***	***Without Correction***	***With Best Correction***
Right Eye (OD)				
Left Eye (OS)				
Both (OU)				
Peripheral Vision in Degrees				
Right Eye (OD)				
Left Eye (OS)				
Both (OU)				

Prognosis: _____

In what ways does this eye condition effect mobility? _____

_____

Clinic/Office Name: _____ *Phone:* _____

Address: _____

Dr. Signature: _____ *Date:* _____

Please Indicate → *Ophthalmologist* *Optometrist*