DOGS WITH WINGS
ASSISTANCE DOG SOCIETY

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CONFIDENTIAL

OPHTHALMOLOGIST MEDICAL REPORT

OPHTHALMOLOGIST REPORT

Applicant's Name:_____ Phone:_____

Address: _____

Date of Last Examination: _____

DETAILS OF BLINDNESS

Cause of Visual Loss: _____

Is Applicant Legally Blind? ☐Yes ☐No Onset of Visual Loss:_____

Does the patient have functional low vision? _____

VISION LOSS: Stable:_____ Progressive:_____ Likely to improve:_____ Photosensitive:_____

RESIDUAL VISION:	**No Light Perception**	**Some Light Perception**	**Gross Movement**	**Count Fingers**	**Read with Lens**
Right Eye					
Left Eye					

Degree of field loss Right Eye _____ Left Eye _____

Ocular Medications:_____

Additional Comments: _____

Physician's Signature: _____ Date:_____

Print Name: _____ License # _____

Phone #_____ Fax: _____

Address: _____

***NOTE: PLEASE RETAIN A COPY OF THIS COMPLETED FORM FOR YOUR FILES**