HADLEY
INSTITUTE FOR THE BLIND AND VISUALLY IMPAIRED

EYE REPORT

To be completed by a physician, eye specialist or blindness professional.

Patient's name: _____ DOB: _____

Street address: _____

City: _____ State: _____ Zip: _____

	O.D.	O.S.		O.D.	O.S.
Visual acuity	20/____	20/____	Object perception	____	____
Vision field (degree)	____	____	Hand movements	____	____
Totally blind	____	____	Counts fingers	____	____
Light perception	____	____			

1. Does the patient meet the standard definition of legal blindness?
   ☐ Yes ☐ No
   Is the Condition: ☐ Progressive ☐ Stable ☐ Unstable
2. Does the vision loss significantly affect daily living? ☐ Yes ☐ No
   If yes, and the individual is not legally blind, provide supportive documentation to indicate how: _____
3. Diagnosis (each eye): _____

Name: _____ Phone: _____

Street address: _____

City: _____ State: _____ Zip: _____

Are you a: ☐ Physician ☐ Eye Specialist ☐ Blindness Professional

RETURN PROMPTLY TO: **Hadley Institute for the Blind and Visually Impaired**
Student Services Department
700 Elm Street, Winnetka, IL 60093-2554
Telephone: 800.526.9909 Fax: 847.446.9820

Physician or Specialist Signature: _____

Date: _____