

Professional Vision Report©



Nebraska Foundation
for Children's Vision
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Child's Name _____ Date _____

Visual Acuity at 20 feet:

Entering R 20/ _____ L 20/ _____
With new correction R 20/ _____ L 20/ _____

Visual Acuity at 16 inches:

Entering R 16"/ _____ L 16"/ _____
With new correction R 16"/ _____ L 16"/ _____

External Eye Health: ___ Normal ___ Other

Internal Eye Health: ___ Normal ___ Other

Refractive Analysis: ___ Myopia (nearsighted) ___ Hyperopia (farsighted) ___ Astigmatism

Vision/Binocularity Analysis:

	<u>Pass</u>	<u>Borderline</u>	<u>Fail</u>	<u>Not Tested</u>
Eye alignment at distance	_____	_____	_____	_____
Eye alignment at near	_____	_____	_____	_____
Depth Perception	_____	_____	_____	_____
Color Vision	_____	_____	_____	_____
Focusing amount	_____	_____	_____	_____
Focusing flexibility	_____	_____	_____	_____
Focusing lag (accuracy)	_____	_____	_____	_____
Convergence (crossing) ability	_____	_____	_____	_____
Saccade (rapid) eye movements	_____	_____	_____	_____
Pursuit (tracking) eye movements	_____	_____	_____	_____

Visual Perceptual Analysis:

___ Visual perceptual problems suspected by history
___ Visual perceptual deficits diagnosed during testing

These findings may contribute to the symptoms noted on the *Vision Observation & Communication Form*:

___ yes ___ no

Comments:

Treatment:

___ No correction necessary
___ No change in present prescription
___ New prescription needed
___ Medical treatment needed for: _____
___ Vision Therapy needed for: _____
___ Recommend scheduling Visual Perceptual Evaluation
___ Follow-up recommended _____

To be worn for:

___ Constant wear
___ Distance vision only
___ Near vision only
___ May be removed for recess

Classroom Recommendations:

Other:

If you have any questions please contact our office.

Dr. _____ Date _____ Phone _____

I give permission to release this information to my child's school. _____ Date _____

(Parent)

Original – Doctor

Copy #1 – Parent

Copy #2 – School Nurse