CLAIMANT:
CASE NUMBER:
DEA:

TREATING SOURCE SUMMARY OF VISION FINDINGS

1. DIAGNOSIS: OD_____

   OS_____

2. DISTANCE VISUAL ACUITY:

   Without correction (leave blank if not checked): OD_____ OS_____ Date_____

   With correction (leave blank if not tested) OD_____ OS_____ Date_____

   Most recent **manifest refraction:** Date _____ Check here if unknown ☐

   OD _____ = 20/_____

   OS _____ = 20/_____

3. Describe any pathological findings:_____

4. What surgery has been performed? None ☐

   OD _____ Date_____

   OS _____ Date_____

5. Has formal **Visual Field** testing been done? Check all that apply.

   ☐ No. ☐ No significant visual field deficit expected.

   ☐ Yes. Was this a reliable field consistent with ocular pathology? ☐ Yes ☐ No

   Date of test _____

   Please include the visual field printouts with this report.

6. Indicate earliest date:

   Best corrected VA in the better eye was limited to 20/200 or worse:

   N/A ____ Date: _____

   Residual visual field in the better eye was 20 degrees or less in widest diameter:

   N/A ____ Date: _____

   Please include supporting clinic notes or VF test results for that date.

7. Please comment on **treatment plan** and **prognosis** over the next 12 months:

_____

_____

_____

Signature of: Physician ☐ ☐ ☐ Optometrist ☐ Date

_____ (___) _____

MD/OD Name (please print) Phone No. Best time to contact you