Wisconsin Department of Public Instruction
OCULAR REPORT FOR CHILDREN WITH A KNOWN OR SUSPECTED VISUAL IMPAIRMENT
PI-2015 (Rev. 10-13)

INSTRUCTIONS: Ocular information to be completed by a vision care specialist (ophthalmologist or optometrist). Send a completed copy to the referring individual or to the child's school district.

CONFIDENTIAL *TYPE OR PRINT* **COMPLETE BOTH PAGES**

I. GENERAL INFORMATION
To be completed by Teacher/Guardian

Student's Name	Sex ☐ Female ☐ Male	Date of Birth
Name of Parent	Address of Parent *Street, City, County, State, Zip*	Telephone *Area/No.*
Signature of Parent* ➢		Date Signed *Mo./Day/Yr.*

**Consent*: Parent signature for Voluntary Release to county agency (if the child is B-3), local school district, Department of Public Instruction for purposes of educational programming and/or registry with the American Printing House for the Blind. This consent can be revoked at any time, cannot be redisclosed to others for any purpose, and is valid for three years from date signed.*

Return completed form to (Name & Title)	Address or Fax	Return Date

II. Background Information
To be completed by Teacher/Guardian

Questions and Concerns by Teacher of Visually Impaired, Caregiver, or Service Provider

☐ This child is known to have a documented hearing loss

☐ This child is known to have an additional disability. *If so, describe.*

III. Ocular Information
To be completed by Eye Care Specialist/Physician

Visual Acuity	Distant Vision: Without Correction	Distant Vision: With Best Correction	Distant Vision: Measured at what distance	Near Vision *in M Sizes*: Without Correction	Near Vision *in M Sizes*: With Best Correction	Near Vision *in M Sizes*: Measured at what distance	Prescription: Sph.	Prescription: Cyl.	Prescription: Axis	Prescription: Add
Right Eye (O.D.)										
Left Eye (O.S.)										
Both Eyes (O.U.)										

Instruments Used
☐ Preferential looking tests
☐ VEP Visual Evoked Response
☐ Lighthouse
☐ Feinbloom
☐ Snellen
☐ Lea Symbols
☐ HOTV
☐ Tangent Screen
☐ Other

If unable to test, does the diagnosis suggest a visual acuity of 20/70 or less in the better eye after correction or a field restriction of 50° or less?

☐ Yes ☐ No

Field Loss	Widest Diameter of Remaining Visual Field *In degrees*	Is Child Legally Blind from Field Restriction: ***20° or less***
Tested ☐ Yes ☐ No *If Yes* ☐ Central ☐ Peripheral	☐ O.D. ☐ O.S.	☐ Yes ☐ No

Does the Child Exhibit Deficits in:

☐ Color Vision ☐ Depth Perception ☐ Night Vision

IV. CAUSE OF BLINDNESS AND VISUAL IMPAIRMENT
To be completed by Eye Care Specialist/Physician

Present ocular and/or cortical (cerebral) condition(s) responsible for vision impairment and Etiology.

Etiology:

Present Ocular Pathology	Cortical Visual Impairment
☐ O.D. ☐ O.S. ☐ O.U.	☐ Yes ☐ No

V. PROGNOSIS AND RECOMMENDATIONS
To be completed by Eye Care Specialist/Physician

Student's Vision Impairment

☐ Stable ☐ Degenerative ☐ Potentially Degenerative ☐ Fluctuating ☐ Uncertain

Recommended Treatment

☐ Patching ☐ Drop ☐ Pressure Checks ☐ Low Vision Evaluation
☐ Other *Specify:*

Glasses or Contacts *Check all that apply*

☐ Prescription ☐ Tinted Lenses/Sunglasses ☐ Safety Lenses ☐ Not Needed
☐ Worn constantly ☐ Worn for distance viewing ☐ Worn for close work

Physical Activities *Is there a medical reason for limiting participation in contact sports or physical education?*

☐ No
☐ Yes *If yes, explain.*

Student is At Risk For Retinal Detachment	Other Concerns *Specify*:
☐ Yes ☐ No	

Were Low Vision Aids Recommended?

☐ No ☐ Yes *If Yes, List.*

VII. SIGNATURES
To be completed by Eye Care Specialist/Physician

Name of Examiner *Please Print*	Date of Examination *Mo./Day/Yr.*	Recommended Date for Next Exam *Mo./Day/Yr.*	
Signature of Examiner ➢		☐ M.D. ☐ O.D.	Date Signed *Mo./Day/Yr.*
Address *Street, City, State, Zip*			Telephone *Area/No.*