OccuPaws Guide Dog Association

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# OPHTHALMOLOGIST / OPTOMETRIST REPORT

**Applicant:** This form must be completed by your Ophthalmologist or Optometrist.

**Physician:** Your patient has applied for a guide dog to enhance his/her mobility and independence. Although our training sessions are conducted in the patients' home environment environment, we may travel to different locations within Southern Wisconsin. Your information will help us provide your patient with the training and instruction most suited to their needs. Thank you for your assistance.

Applicant's name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ Date of Birth: _____ Height: _____ Weight: _____

**Details of Blindness:** Is Applicant legally blind? ☐ Yes ☐ No Date of last examination: _____

| **Cause of vision loss:** | **Primary** | **Secondary** |
|---|---|---|
| OD | | |
| OS | | |

Is Applicant's vision loss considered to be:

Progressive _____ Stable _____ Likely to improve _____ Uncertain _____

In what year did blindness occur? _____ How long have you attended this patient? _____

Visual Acuity

| | | | |
|---|---|---|---|
| With correction: | OD _____ | OS _____ | OU _____ |
| Uncorrected: | OD _____ | OS _____ | OU _____ |

Visual Fields

| | | | |
|---|---|---|---|
| Central: | OD _____ | OS _____ | OU _____ |
| Peripheral: | OD _____ | OS _____ | OU _____ |

Please describe residual vision:

| | No light perception | Some light perception | Gross movement | Count fingers | Read with lens |
|---|---|---|---|---|---|
| OD | | | | | |
| OS | | | | | |

Please list any ocular medications: _____

Comments: _____

**Date of exam on which report is based:** _____

_____
**Physician's Signature**

Doctor's name: _____
*Please print*

Telephone: (____) _____

Hospital / Clinic Stamp