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