



Cincinnati Association for the
Blind & Visually Impaired

2045 Gilbert Avenue, Cincinnati, Ohio 45202 • Phone: 513-221-8558 • Fax: 513-221-2995

OPHTHALMOLOGICAL EXAMINATION REPORT FOR EARLY CHILDHOOD AND YOUTH SERVICES

Child's Name: _____ DOB: _____
Parents Name: _____
Address: _____
Phone: _____

Date of Child's First Examination: _____
Date of Most Recent Examination: _____
Next Scheduled Examination: _____

Visually Acuity: OD: _____ OS: _____ OU: _____
Visual Fields: OD: _____ OS: _____ OU: _____

Diagnosis: OD: _____
OS: _____

Prognosis: OD: _____
OS: _____

Etiology: _____

Surgeries Performed: _____

Medications Prescribed/Purpose/Side Effects: _____

Corrective Lenses Prescribed: _____

Types of Vision Exams Performed: _____

Other Comments/Activity Restrictions: _____

Date

Signature, Examining Ophthalmologist

This form may not be copied without permission from the Cincinnati Association for the Blind & Visually Impaired.

PROTECTED HEALTH INFORMATION STATEMENT

The privacy of all medical records and other individually identifiable health information must be protected at all times. Information relating to a patient's health care history, diagnosis, condition, treatment, or evaluation shall be considered individually identifiable health information. **Confidentiality of this health information must be maintained at all times.** This information has been disclosed to you from confidential records of which may be protected by federal and/or state law. *With regard to its use and/or disclosure of protected health information, the recipient of this information hereby agrees to safeguard all protected health information from misuse of any and all kinds as required by law.*