AB-5 (R 4/93)

CERTIFICATE BY OPTOMETRIST OR OPHTHALMOLOGIST

_____ COUNTY

INSTRUCTIONS TO EXAMINERS: _____
(ADDRESS)

Only examiners designated by the State Department of Social Services are authorized to make examinations for Aid to the Blind purposes.

A person shall be considered as "blind" for the purpose of the Aid to the Blind Act if the central visual acuity of the better eye, corrected with glasses, is not more than 20/200, and such person, if otherwise eligible, if otherwise eligible, may receive monthly "Aid to the Blind" payments and/or such eye surgery and treatment as may be required. Other persons (not blind within the foregoing definition) in need of surgery or treatment to prevent blindness or restore sight may be given surgery or treatment under the Aid to the Blind Act and may, if otherwise eligible, also be given temporary monthly Aid to the Blind Assistance pending outcome of such surgery or treatment. Persons with visual acuity better than 20/200 may be considered blind if their visual field is so constricted that in the maximum meridian the field does not encompass more than 20 degrees. (This does not mean- 20 degrees from fixation, but a total excursion of 20 degrees). Use a perimeter of 33 cm. radius and a white test object of 6mm. Fields are not necessary unless the visual acuity is greater than 20/200 and there is a gross field defect

Use Snellen notations in recording visions 20/200, 10/200, etc. If applicant is unable to read the 200 foot" letter on the Snellen Chart at a distance of 20 feet, he should approach the chart until he can read it. Report the visual acuity as 3/200, etc. with the numerator indicating the distance at which he reads, and the dominator indicating the standard letter he is able to read. If unable to read the largest Snellen letter at any distance, but can see hand movements, record "hand movements" at the determined distance. If unable to see hand movements, report "light perception" or "no light perception". Do not use such ambiguous terms as "blind," "nil," "none," "zero," etc.

COUNTY COMPLETION ONLY

SOC. SEC. NO _____ H.H. Case No. _____

Applicant's Name _____ Sex _____

Address _____ County _____

Date of Birth _____

OPTOMETRISTS FILL OUT FRONT SHEET ONLY. –OPHTHALMOLOGISTS FILL OUT BOTH SIDES.

(Duplicate Copies to be Completed and Returned to County Department)

Date of Examination _____

VISUAL ACUITY: (See Instructions)

	Distant vision without glasses	Distant vision with correction determined at this examination
Right	_____	_____
Left	_____	_____

Have you personally, in this examination, ascertained to what extent vision can be improved with test lenses? _____

If a gross field defect is significant, (see instructions), please include a record of the field with this report. _____

Is the applicant blind within the meaning of the Aid to the Blind Law? _____

Should applicant be referred for any other type of examination? _____

Recommendations: _____

Remarks: _____

"I UNDERSTAND THE POLICY OF THE DEPARTMENT OF SOCIAL SERVICES CONCERNING DISCRIMINATION UNDER THE CIVIL RIGHTS ACT OF 1964 WHICH PROHIBITS PAYMENT TO ANY VENDOR PROVIDING CARE AND SERVICES UNDER FEDERALLY ASSISTED PROGRAMS UNLESS SUCH CARE AND SERVICE IS PROVIDED WITHOUT DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, RELIGION, SEX, OR NATIONAL ORIGIN. I HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH

_____
Signature of Examining Optometrist

Ophthalmologists are to fill in the additional medical findings on the opposite side of this sheet.

AB-5 (R 4/93)

OBJECTIVE MEDICAL EXAMINATION: To include study under mydriatic, unless contra-indicated. Describe briefly any significant abnormal findings. If normal, leave blank

LIDS, SCLERA, OCULAR MOVEMENTS, CONJUNCTIVA, LACRIMAL APPARATUS

RIGHT_____

LEFT_____

CORNEA, IRIS, PUPIL, LENS, VITREOUS.

RIGHT_____

LEFT_____

OPTIC NERVE, RETINA, CHOROID, MACULA

RIGHT_____

LEFT_____

TONOMETRIC READING R_____ L_____

If the applicant has ever received an important ocular injury please describe and give date_____

_____

If the applicant has ever had ocular surgery, please describe and give date and name of surgeon_____

What is the pathological lesion causing blindness? (State etiology if known.)_____

_____

Can the vision be improved by treatment, either medical or surgical?_____

Do you know of any systemic condition that may alter the prognosis for vision or life _____

RECOMMENDATIONS: _____

REMARKS: _____

"I UNDERSTAND THE POLICY OF THE DEPARTMENT OF SOCIAL SERVICES CONERNING DISCRIMINATION UNDER THE CIVIL RIGHTS ACT OF 1964 WHICH PROHIBITS PAYMENT OF ANY VENDOR PROVIDING CARE AND SERVICES UNDER FEDERALLY ASSISTED PROGRAMS UNLESS SUCH CARE AND SERVICE IS PROVIDED WITHOUT DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, RELIGION, SEX, OR NATIONAL ORIGIN. I HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH."

_____

Signature of Examining Ophthalmologist

_____

Address

Applicant must be reexamined before _____20____

Approved _____
Date

Disapproved _____
Date

Comments

_____

_____

_____

_____

State Consulting Ophthalmologist