



# Functional Vision

Office Use Only					Acrostic			Staff ID#				
SOF ID#												

## LETTER LITERACY TEST

1 Number of letters read correctly:   letters

2 Were 10 or more letters read correctly?

Yes →

No →

## BAILEY-LOVIE DISTANCE VISUAL ACUITY

3 Does the participant usually wear glasses and/or contact lenses for distance tasks?

Yes  No  Both **V8BLGLAS**

Is the participant wearing glasses and/or contact lenses for the Bailey-Lovie test?

Yes  No **V8BLGLSN**

What is the participant wearing - glasses or contact lenses?

Glasses →   
 Both →  **V8BLGLCT** **V8BLTPGL**

Contact lenses →  **V8BLTPCT**  
 Distance  Bifocal  Monovision (one eye corrected for near, one for distance)

4 Was the Bailey-Lovie test administered?

Yes  No **V8BLTEST**

Why not? Check the main reason test was not administered.

**V8BLWHYN**  Participant fatigued  Unable to see chart  Did not understand  Refused

5 LEFT EYE

Which distance was used?

10 feet  5 feet

Participant unable to read chart at 5 feet

Which chart was used?

Chart 1  Chart 2  Home visit light box

Number of letters read correctly:   letters

6 RIGHT EYE

Which distance was used?

10 feet  5 feet

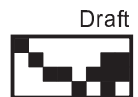
Participant unable to read chart at 5 feet

Which chart was used?

Chart 1  Chart 2  Home visit light box

Number of letters read correctly:   letters

**V8RACCOR**





# Contrast Sensitivity

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### 1 Glasses/Contact Lenses/Lens implants (Check all that apply):

- Does not wear glasses **V8GLNONE**
- Does not wear contact lenses **V8GLMOST**
- Wears glasses most of the time **V8CTMOST**
- Wears contact lenses most of the time **V8GLDIFF**
- Different glasses for distance and near **V8LLIMP**
- Left eye lens implant **V8RLIMP**
- Right eye lens implant
- Wears glasses for reading over contact lenses **V8CTREAD**
- Wears glasses for reading/near viewing only **V8GLREAD**
- Always wears multifocals **V8BIFOC**
- Wears glasses for distance only **V8GLDIST**
- Wears one contact lens for near and one for distance **V8CTDIST**

**V8CTEYE**

<input type="radio"/> R is near/L is distance
<input type="radio"/> L is near/R is distance

### 2 Was the Contrast Sensitivity test administered? **V8CSWHYN**

**V8CSDONE**  Yes  No →

- |  |  |
|--|--|
| <input type="radio"/> Participant fatigued | <input type="radio"/> Did not understand |
| <input type="radio"/> Unable to see chart  | <input type="radio"/> Refused            |

### HOME VISIT ONLY: Illumination (Use Vistech Meter)

- Top right corner OK (green light)
- Bottom left corner OK (green light)

### 3 RIGHT EYE

Which distance was used?

- 10 feet  5 feet **V8RCSDS**
- Participant unable to read chart at 5 feet

Number of circles correctly identified:

<b>V8RCSAV</b>	<input type="text"/>	<input type="text"/>	Row A	<input type="text"/>	<input type="text"/>	Row D
<b>V8RCSHAV</b>	<input type="text"/>	<input type="text"/>	Row B	<input type="text"/>	<input type="text"/>	Row E
<b>V8RCSLAV</b>	<input type="text"/>	<input type="text"/>	Row C			

### 4 LEFT EYE

Which distance was used?

- 10 feet  5 feet **V8LCSDS**
- Participant unable to read chart at 5 feet

Number of circles correctly identified:

<input type="text"/>	<input type="text"/>	Row A	<input type="text"/>	<input type="text"/>	Row D
<input type="text"/>	<input type="text"/>	Row B	<input type="text"/>	<input type="text"/>	Row E
<input type="text"/>	<input type="text"/>	Row C			

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SOF ID#

Acrostic

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1 Was visual acuity measured in BOTH eyes by the Humphrey Autorefractor?

V8HADONE

- Yes
- No

- Right Eye Not Tested
- Left Eye Not Tested
- Neither Eye Tested

Record information for the eye that was tested

GO to Intraocular Pressure

V8HANOT

2 Visual acuity with "best correction" as determined by the Humphrey Autorefractor (with glasses removed):

RIGHT EYE

LEFT EYE

20/ V8RACCR

20/ V8LACCR

3 "Best correction" results from the Humphrey Autorefractor:

RIGHT EYE

+ V8RBCSP sphere

-

+ V8RBCCYL cylinder x V8RBCAX axis

LEFT EYE

+ V8LBCSP sphere

-

+ V8LBCCYL cylinder x V8LBCAX axis





# Intraocular Pressure

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**Be sure to instill a drop of ophthalmic (anesthetic) into each eye before you check intraocular pressures.**

- 1 Has the participant had eye surgery within the past two weeks?  Yes  No **V8TWWKSG**
- 2 Is the participant allergic to any eye drops?  Yes  No **V8ALRGDD**
- 3 Has the participant's doctor ever told her to not be dilated?  Yes  No **V8DRDLT**

**If the answer is "YES" to 1, 2, OR 3, DO NOT check Intraocular Pressure. GO TO Eye Photo, after answering Question 4.**

4 Was intraocular pressure measured in BOTH eyes?

**V8IODONE**

Yes  No →

**V8IONOT**

Right Eye Not Measured → **Record information for the eye that was tested**

Left Eye Not Measured → **Record information for the eye that was tested**

Neither Eye Measured → **GO TO EYE PHOTO**

5 Time intraocular measurement taken:  :   A.M.  P.M.

6 Intraocular measurements:

<b>RIGHT EYE</b>	Avg. IOP <b>V8R1IOP</b> mmHg	<b>V8R15PCT</b>
	% of error <b>V8R1PCT</b>	
<b>LEFT EYE</b>	Avg. IOP <b>V8L1IOP</b> mmHg	<b>V8L15PCT</b>
	% of error <b>V8L1PCT</b>	

7 Was there an anterior chamber intraocular lens present? **V8LANTCH**

**V8RANTCH** RIGHT EYE  No  Yes → Do Not Dilate LEFT EYE  No  Yes → Do Not Dilate

8 Were the angles shallow on penlight exam? **V8LPNLT**

**V8RPNLT** RIGHT EYE  No  Yes → Do Not Dilate LEFT EYE  No  Yes → Do Not Dilate

9 Was the eye pressure equal to, or greater than 30mmHg? **V8L30**

**V8R30** RIGHT EYE  No  Yes → Do Not Dilate LEFT EYE  No  Yes → Do Not Dilate

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





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# Eye Photo

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**IF INTRAOCULAR PRESSURE WAS NOT CHECKED, DO NOT DILATE. TAKE THE PHOTOS WITHOUT DILATING THE EYES.**

**IF THE ANSWER TO QUESTION 7, 8, OR 9 ON THE INTRAOCULAR PRESSURE FORM WAS ANSWERED YES, DO NOT DILATE. TAKE EYE PHOTOS WITHOUT DILATING THE EYES. OTHERWISE, DILATE AND THEN TAKE EYE PHOTOS.**

4 Record the diameter of the pupils in mm PRIOR to dilating to help determine if the participant is dilated. If the participant did not have one or both eyes dilated due to criteria above, record diameter after 10 minutes in a dark room or after patched for 10 minutes.

RIGHT EYE Before dilation:      mm After dilation:      mm

*V8RDRPNU*       dilating drops not used

LEFT EYE Before dilation:      mm After dilation:      mm

*V8LDRPNU*       dilating drops not used

Were photos of RIGHT EYE taken?       Yes     No

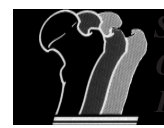
Were photos of LEFT EYE taken?       Yes     No

Canon Fundus Photos      Film Roll #         Film Type

Check as completed:

	<u>RIGHT EYE</u>	<u>LEFT EYE</u>
a. (N) Photo #1 <i>V8R1FLM</i>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <i>V8L1FLM</i>
b. (+) Photo #2 <i>V8R2FLM</i>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <i>V8L2FLM</i>
c. External #3 <i>V8R3FLM</i>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <i>V8L3FLM</i>
d. Retakes? <i>V8RRTK</i>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <i>V8LR TK</i>

Comments on photos: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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# Vision Measures

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1 Did the participant complete ANY of the vision measurements listed below (besides the Visual Acuity exam)?

Yes  No →

V8VSNEXM

**STOP. Complete only this page of the Vision Forms Packet and submit to data system. DO NOT SEND REST OF VISION FORMS.**

## Vision Checklist

(Complete the vision measures in the following order and indicate which measures were completed by filling in the circle):

Vision Interview

Ocular History →

**Examiner rating of ocular history:**

Excellent  Satisfactory  Unsatisfactory

**Comments:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Functional Vision

Visual Acuity (Form is in the Clinic Interview Packet)

Contrast Sensitivity

Auto Refraction

Intraocular Pressure

Eye Photographs

Dilation

