

REACH
Regional Educational Assessment & Consultation Services
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FUNCTIONAL VISION INQUIRY

Date: _____

To: _____

From: Educational Consultants for the Visually Impaired

Re: **Student:** _____

Date of Birth: _____

1. Present Eye Condition: _____
Etiology of the Condition: _____

2. Acuity (with Correction)

**Standard Testing
Distance of 10 feet**

**Standard Testing
Distance at 16"**

OD	Right Eye:	Distance	_____	Near	_____
OS	Left Eye:	Distance	_____	Near	_____
OU	Both Eyes:	Distance	_____	Near	_____

3. Field of Vision (restriction in degrees – Please describe. Example: Scotomas)

4. Is there a diagnosis or characteristics of Cortical Vision Impairment? ____ Yes ____ No
If yes, please describe: _____

5. Is the visual impairment likely to:
 Improve deteriorate remain stable

6. Does child require glasses or contact lenses? _____

7. Describe special treatment that may be required (e.g. patching, eye drops, lighting).

Should there be any restrictions in the child's activities? _____

Should the teacher be alert to any particular symptoms that would signal the need for medical attention? (e.g. eye poking, head banging, squinting, photophobia, etc.)

Doctor's Signature: _____

Date: _____