WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICAL REVIEW TEAM (MRT)

OPTOMETRIST'S REPORT

MA ID Number/Pending Medicaid Number: _____

Patient's Name: _____ Date of Birth: _____

Street Address: _____

City / State / Zip: _____ Age at onset of blindness: _____

Sex: ☐ Male ☐ Female Race: _____

Ocular Motility: _____

_____

Nerve Heads (Describe nerve heads and vessels emerging from nerve heads): _____

_____

Status of Corneal: ☐ Clear ☐ Cloudy

	Without Glasses		With Glasses	
	Distance (20 ft.)	Near (14 in.)	Distance (20 ft.)	Near (14 in.)
Right Eye	_____	_____	_____	_____
Left Eye	_____	_____	_____	_____

Peripheral Vision With Hand Motion: O.D. _____ O.S. _____

Peripheral Vision (See Note 2)

Is there any limitation in the field of vision? ☐ Yes ☐ No

If so, indicate the best vision obtainable for each quadrant, by small spot light or test object.

_____

_____

_____

Please indicate size of test object: _____

Opinion as to whether visual acuity might be improved:

By Glasses: _____

By Other Means: _____

Remarks: _____

Examination Date: _____ Optometrist Signature: _____

Date of Report: _____ Address: _____

NOTE 1: Measurements will be assumed to be stated in the Sneilen formula (either feet or inches) unless otherwise noted. If exact measurements of central vision cannot be given, describe the test used so as to indicate the distance and the size of the test object. Examples: Counts fingers at three feet; hand movement at three feet; light perception only.

NOTE 3: Tests should be made with patient fixing one eye on a point three feet straight ahead and with objects held at a distance of three feet from the fixation point in the quadrant of the field under examination, the other eye to be kept closed or covered.

Please use Page Two for recording re-examinations, operations, treatment, etc.

HISTORY OF EYE INJURY

Name: _____ Date of Accident: _____

Address: _____

Which eye injured? ☐ Right ☐ Left ☐ Both Age when accident occurred: _____

What was the nature of the accident; was there a perforating injury; was the eye cut? Describe in detail.

_____

_____

_____

What was individual doing when the injury occurred; cutting with scissors; using knife, hammering, filing, chopping wood, etc. If an automobile accident, state whether injury was from broken glass, splinters, a blow. Describe in detail: _____

_____

Was any operation performed? ☐ Yes ☐ No _____

Was there any sight remaining in the injured eye after the accident? ☐ Yes ☐ No _____

When did the injured eye become blind? _____

If the injured eye was totally blind, did the doctor advise removing it? ☐ Yes ☐ No

Was the injured eye, if sightless, removed? ☐ Yes ☐ No Date: _____

HISTORY OF THE BETTER EYE

How soon did the sight in the **better** eye begin to disappear? _____

How soon after it became affected was an eye specialist consulted? _____

What was his advice? _____

When did the **better** eye become blind? _____

Please give any further details in connection with the accident:

_____

_____

_____

_____

Date of Report: _____ Optometrist Signature: _____

RE-EXAMINATIONS

Date	Best Corrected Vision		Changes in Eye Condition	Recommendations (Further examination of treatment – Specify)	Optometrist's Signature
	Right Eye	Left Eye			