

The Hadley School for the Blind

EYE REPORT

U.S. student/applicant: To be completed by a physician, eye specialist or blindness professional.

Patient's name: _____

Street address: _____

City: _____ State: _____ Postal Code: _____

	O.D.	O.S.		O.D.	O.S.
Visual acuity	20/____	20/____	Object perception	____	____
Vision field (degree)	____	____	Hand movements	____	____
Totally blind	____	____	Counts fingers	____	____
Light perception	____	____			

1. Does this patient meet the standard definition of legal blindness?
 Yes No
2. Condition is: Progressive Stable Unstable
Does your vision loss significantly affect your daily living? Yes No
If yes, and you are not legally blind, provide supportive documentation to indicate how: _____
3. Diagnosis (each eye):

Name (physician, eye specialist, blindness professional): _____

Street address: _____

City: _____ State: _____ Postal Code: _____

Area code and phone number: _____

RETURN PROMPTLY TO: The Hadley School for the Blind
Student Services Department
700 Elm Street, Winnetka, IL 60093-2554

Telephone: 800-526-9909 Fax: 847-446-9820

Physician or eye specialist's signature: _____ Date _____