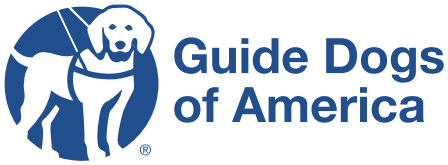
GUIDE DOGS OF AMERICA

Ophthalmologist Report



SEND TO:
Guide Dogs of America
13445 Glenoaks Blvd.
Sylmar, CA 91342
Attn: Admissions

Telephone & Fax: 818-833-6428
Email: Admissions@GuideDogsofAmerica.org

PATIENT INFORMATION					
Last Name		**First**		**M.I.**	
Date of Birth					

VISION INFORMATION			
Is the patient legally blind?	**YES** ☐	**NO** ☐	
Cause of patient's blindness:			
Year patient's blindness occurred:			
Is the patient's vision loss:	**Stable** ☐	**Progressive** ☐	**Likely to improve** ☐
Degree of field loss:	**Right Eye:**	**Left Eye:**	

Residual Vision:	**No Light Perception**	**Some Light Perception**	**Gross Movement**	**Counts or Read With Fingers/Lens**
Right Eye:				
Left Eye:				

OCULAR MEDICATION

Does the patient take ocular medication(s) on a regular basis? If yes, please list below:

Name of Medication	Amount	Purpose:

TRAVEL AND INDEPENDENCE LEVEL

In your opinion, does the applicant travel visually?	**YES** ☐	**NO** ☐
Does the applicant travel independently?	**YES** ☐	**NO** ☐
In your opinion, will the patient's general health enable him/her to undergo 1 month of daily training and exercise (approximately ½ to 1 hour of moderate walking twice daily with a dog)?	**YES** ☐	**NO** ☐

Any additional comments about the care of your patient are welcome:

PHYSICIAN'S SIGNATURE

Print Name:			
Physician's Signature:			
Physician's Address:			
Physician's Phone:		**Physician's Fax:**	
License #:		**Date:**	