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:		Phone:			

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 ☐
Acuity (corrected):	OD:	OS:	
Visual Field (degrees)	OD:	OS:	

Residual Vision:	No Light Perception	Some Light Perception	Gross Movement	Counts or Read With Fingers/Lens
OD:				
OS:				

OCULAR MEDICATION

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

Name of Medication	Amount	Purpose:

Comments:

PHYSICIAN'S SIGNATURE

Print Name:	
Physician's Signature:	
Physician's Address:	

Physician's Phone:		**Physician's Fax:**	
License #:		**Date:**	