JAMAICA SOCIETY FOR THE BLIND

OPHTHALMIC REPORT FORM

LAST NAME		FIRST NAME	
DATE OF BIRTH	AGE	ADDRESS	
TELEPHONE NUMBER			
REFERRED BY			
VISUAL ACUITY		CAUSE OF BLINDNESS	
CAN THE CAUSE OF BLINDNESS BE CURED, LEADING TO RESTORATION OF SIGHT?		YES [ ]	NO [ ]
IF YES, SPECIFY THE NATURE OF TREATMENT REQUIRED			
MEDICATION CURRENTLY BEING TAKEN			
DOES THE MEDICATION CAUSE DROWSINESS?		YES [ ]	NO [ ]
COMPLETED BY		OPHTHALMOLOGIST/OPTOMETRIST NAME	
TELEPHONE NUMBER (S)			
		ADDRESS	
SIGNATURE		DATE	