the
Chickasaw Nation
Division of Education
Vocational Rehabilitation Program
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Bill Anoatubby
Governor

VISUAL CONSULTANT'S REVIEW

Consumer name:		**Case number:**	
County:		**Counselor:**	

Instructions to Visual Consultant: The following information for the individual listed above will be used in determining his/her eligibility for services and/or in developing a vocational rehabilitation program. Your attention in this matter is greatly appreciated. **PLEASE TYPE OR PRINT NEATLY.**

1. Visual diagnosis:

2. Criteria diagnosis is based on:

3. Characteristics of conditions: ❑ **Stable** ❑ **Progressive** ❑ **Improving** ❑ **Recurrent** ❑ **Permanent** ❑ **Communicable**

4. Obstacles/impediments diagnosis creates for consumer in attaining/maintaining suitable employment:

5. Prognosis of attaining/maintaining suitable employment with vocational rehabilitation services:

6. Recommendation of vocational services consumer should receive, if any, and other comments:

7. Intraocular pressure: R ______________________________ **L** ______________________________

8. Does consumer have useful binocular vision in all directions with glasses?
For distance: ______________________________ **For near:** ______________________________

Form no. CS03 EDU VR 7/2008

Visual Consultant's Review – Cntd.

Consumer name:		Case number:	
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9. Is consumer's muscle function normal or restricted?

10. Is stereopsis present? ❑ Yes ❑ No

COLOR PERCEPTION: Normal ___________________ Achromatopsia ___________________

VISUAL FIELD: Normal ___________________ Abnormal _______________________

11. VISUAL ACUITY (Snellen Notation (20 feet for distance, 14 inches for reading)):

	Right eye	Left eye
Distance without correction:		
Distance with best correction:		
Reading without correction:		
Reading with best correction:		

12. Are glasses or contacts recommended?

13. Are current glasses/contacts appropriate? Is a new pair needed (please provide current RX)?

14. Do you recommend a low vision evaluation or other follow-up evaluations?

15. Can functioning be improved with treatment? If so, what treatment?

16. Additional remarks:

Consultant's printed name: ___________________________________ Title/agency: _____________________

Consultant's signature: ______________________________________ Date: ____________________________

May we contact you if we have further questions? ____

Contact information to use: ____