

REPORT OF OPTOMETRIC SCREENING

(This Form Comes Under the Purview of the Privacy Act of 1974)

Patient Name:		Social Security Number:	
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	

DIRECTIONS FOR THE EXAMINER

- Confirm Authorization:** Check to make sure the patient is authorized to be seen for an ROTC/US Service Academy Exam. Authorization may be given by the Log/Invoice sheet or by calling 1-800-966-9790 for a verbal authorization.
- Complete & Return to CIV Team:** Complete and sign this form and mail it to CIV Team or fax a copy to 800-796-2690 **within 2 days of the examination.**

CONTACT LENSES: IT IS ESSENTIAL TO OBTAIN A CORRECT CONTACT LENS HISTORY

Contact Lenses must be removed at least: **72 HOURS** prior to the exam for Soft Lenses; **21 DAYS** prior to the exam for Rigid Lenses and **90 DAYS** prior to the exam for Orthokeratology or Corneal Refractive Treatment Lenses

Does the Applicant wear Contact Lenses? (mark box with an "X") YES NO

If so, which type of lens? (mark box with an "X") Rigid Soft Ortho-K

How many days prior to the appointment were the contacts removed? _____ **days**

17. Distant Vision		18. Manifest Refraction (Required)			19. Near Vision		
a. Right	b. Corr to	1. SPH	2. CYL	3. AXIS	a. Right	b. Corr to	c. By
c. Left	d. Corr to	4. SPH	5. CYL	6. AXIS	d. Left	e. Corr to	f. By

20. Phoria/Tropia (Far Only) Quantitative assessment only	21. Cover Test (Far Only)	22. Color Vision *	23. Depth Perception
a. ESO^	<input type="checkbox"/> Pass (Phoric) <input type="checkbox"/> Fail (Tropic)	REQUIRED 14 PLATE TEST ONLY	
b. EXO^		Test Used:	1. Titmus/Stereo Circle Arc +
c. RT^ Hyper		No. Passed:	2. Randot Arc +
d. LT^ Hyper		No. Failed:	3. Verhoff

24. PC in mm	25. Motility/Binocularity* <input type="checkbox"/> Passed <input type="checkbox"/> Failed	4. OVT Score _____ (A-F)
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* 22 (Continued). If more than 4 plates are failed on the color vision, the patient

Can distinguish vivid red/vivid green Cannot distinguish vivid red/vivid green

* 25 (Continued). If the Motility/Binocularity is failed, is the patient

Diplopic Suppressing

The meridian(s) in which this occurs: _____

26. Slit Lamp (Without Dilation)
You must provide notes in #27 for ABNORMAL response

Right	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Left	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

27. Notes and Significant History: Elicit and document significant optometric history to include known/reported conditions such as keratoconus or cataract, ocular trauma, ocular surgery. (For military purposes 20/20-1 equates to 20/25)

Typed or Printed Name of Examiner:		Examining Facility Name & Address:	
Signature: _____		City: _____ State: _____ Zip: _____	
Date: _____			