Phyllis Lovell, BSW, MSW, RSW
Executive Director

REPORT OF EYE CONDITION

Name: ______________________________ Worker: __________________________
Date of Birth: ______________________________ Foster Parent: __________________________
Sex: ______________________________ Date of Exam: __________________________
Referred By: ______________________________ Health Card#: __________________________
Reason for Referral: ____
____
____

Vision | With Glasses

Right Eye: ________________________________ Right Eye: __________________________
Left Eye: ________________________________ Left Eye: __________________________

Is sight likely to improve? ________ or Decline: ________ or Remain as at present? ________
Diagnosis: ____
____
____

Are glasses required? Yes: ____________ No: ______________
Treatment Received to Date and Remarks: ____
____
____

Advice as to Treatment and Follow-Up: ____
____
____

____
Optometrist/Ophthalmologist

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