

NWPD Vision Report Form

TO BE COMPLETED BY THE APPLICANT:

APPLICANT'S FULL NAME	DATE OF BIRTH (YY-MMM-DD)	PRONOUNS	
APPLICANT'S ADDRESS	CITY	PROVINCE	POSTAL CODE
Have you ever had eye surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO	If 'Yes,' please indicate the type of procedure and the date it was performed:		

TO BE COMPLETED BY THE ATTENDING OPHTHALMOLOGIST / OPTOMETRIST:

1. VISUAL ACUITY		WITHOUT VISUAL AID	WITH BEST POSSIBLE CORRECTION
	RIGHT EYE	20 /	20 /
	LEFT EYE	20 /	20 /
	BOTH EYES	20 /	20 /
2. HORIZONTAL FIELD OF VISION		TEMPORAL	NASAL
	RIGHT EYE	Degrees: _____ <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	Degrees: _____ <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
	LEFT EYE	Degrees: _____ <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	Degrees: _____ <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
	BINOCULAR VISION (DEPTH PERCEPTION):		<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
Comments and Describe Deficiencies: _____			
3. COLOUR VISION	DETERMINED BY PSEUDO-ISOCROMATIC PLATES OR FARNSWORTH-MUNSELL		<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
	Comments: _____		
4. DATE OF EXAMINATION: (YY-MMM-DD) _____			

TO BE COMPLETED BY THE ATTENDING OPHTHALMOLOGIST / OPTOMETRIST:

NAME	TELEPHONE		
ADDRESS	CITY	PROVINCE	POSTAL CODE
SIGNATURE & STAMP OF OPHTHALMOLOGIST/OPTOMETRIST		DATE (YY-MMM-DD)	