N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

REPORT ON LOW VISION EVALUATION

Name ______________________________ County ______________________

Near Acuity with RX: OD _______ OS _______ Without RX: OD _______ OS _______
Distance Acuity with RX: OD _______ OS _______ OD _______ OS _______

Client Complaints and/or Concerns:

Source of Purchase	Aid Suggested	Catalog Number	Price

Notes regarding visit:

Good candidate for CCTV Evaluation: ☐ YES ☐ NO

Contact Date: ______________________

Evaluation Date: ______________________

Follow up Date: ______________________

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Nursing Eye Care Consultant