State of Israel

Ministry of Education

Pedagogical Director

Special Education Division

Education and Supervision of blind and visually impaired students

shlomit kohen –
National Superintendant

2 Hashlusha St, Tel – Aviv
03-6896093 , 03-6896092
E mail : Visually_impairment@education.gov.il

To give your child the best educational support, please fill in the form below.
In addition, please sign the Parental consent for use of medical data.

(Name and Signature): _____

Questionnaire for Low Vision Clinic Ophthalmologist

Personal Information
First name: _____ Surname: _____
ID No: _____ Date of Birth: _____
Address: _____ City: _____ Phone No: _____

Educational Framework: (Mark X):
( ) Kindergarten ( ) Primary School ( ) Junior High ( ) High School
Name and address of Educational Institution:
_____
Member of Health Fund / Hospital (name, address):
_____
Doctor's Name: _____.

Section to be completed by doctor
Please fill in the following in clear and simple language

Visual Acuity
Distance Vision:
Without correction: Right: _____ Left :_____ both eyes: _____
With optimal correction: Right: _____ Left :_____ both eyes: _____

Near Vision:
Without correction: Right: _____ Left: _____ both eyes: _____
With optimal correction: Right:_____ Left _____ both eyes: _____
Method employed: Jaeger / Finebloom / Snellen / print.

Please circle the appropriate information
Visual Field Loss:
Concentric reduction of 20-40 degrees __ Below 20 degrees__ Tunnel Vision__ Restricted Vision__
Visual Response: (If visual acuity and field of vision cannot be measured)
Left _____ Right _____ Both eyes _____
Tested by: Light __Color __ object ___image ___
Part of Eye Impaired;
Cornea__ iris __lens __vitreous __ retina __optic nerve __eye muscle__ eyelid __visual cortex ___
Visual Diagnosis with explanation in clear language:
_____
_____
_____

Auxiliary tests: EEG, ERG, MRI, CT, VEP

Recommendation for Genetic counseling: yes / no

Prognosis: stable __ deterioration___ surgical intervention should be performed ____

Implications of Vision Disability: night vision ___ photophobia ___ reading ___ sports___ board copying __ Mobility___ Other (specify) _____

Other disabilities: _____

Notes/ Recommendations:
_____
_____

Examination Date: _____ **Doctor's Signature and stamp**: _____

To the Low Vision Specialist

Specialized Visual Aids recommended to child	Visual Ability with Aid while reading
Distance Visual Ability: (Please specify type and strength) With Glasses: Telescopic Glasses: Eye glass mounted telescopes: Neck Telescope: Contact Lenses: Other Accessories:	
Near Visual Ability: (Please specify type and strength) Bifocals: Eye glass mounted magnifier: Low vision Glasses: Closed circuit television - CCTV: Other Accessories:	

Name of Physician / Optometrist: _____
Unit Name: _____
Signature: _____

Date of Previous examination: _____
Current examination date: _____
Date of Next examination: _____