



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 FAMILY SUPPORT DIVISION  
**VISUAL DISABILITY EXAMINATION REPORT**

INDIVIDUAL NAME (FIRST)	(MIDDLE)	(LAST)	DCN	DATE OF BIRTH	DATE OF APPLICATION/ REDETERMINATION
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ADDRESS	PHONE NUMBER
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**EXAMINER: COMPLETE THIS SIDE OF FORM ONLY**

VISUAL ACUITY		IOP	COLOR VISION		BINOCULAR VISION	
NEAR	DISTANCE		PRESENT	ABSENT	DOES PATIENT HAVE BINOCULAR VISION?	
BEST CORRECTED	BEST CORRECTED				YES <input type="checkbox"/> NO <input type="checkbox"/>	
OD						
OS						

RIGHT EYE		LEFT EYE	
DIAGNOSIS		DIAGNOSIS	
1)		1)	
2)		2)	
3)		3)	

CONDITION (CHECK ALL THAT APPLY) (IF ONLY APPLICABLE TO ONE EYE, NOTE WHICH SPECIFIC EYE)

HEREDITARY     
  STABLE     
  RECURRENT     
  PERMANENT  
 PROGRESSIVE     
  IMPROVING     
  COMMUNICABLE

RECOMMENDATIONS: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**IMPORTANT:** IF THE INDIVIDUAL HAS VISUAL ACUITIES GREATER THAN OR EQUAL TO 5/200 WITH OR WITHOUT CORRECTION IN EITHER EYE, **YOU MUST COMPLETE A VISUAL FIELD EXAMINATION** AND ATTACH IT TO THIS FORM.

I, \_\_\_\_\_ [blank for printed name] certify:

- I am an  ophthalmologist, a  physician skilled in disease of the eye, or  an optometrist licensed in good standing in the State of Missouri. My license number is \_\_\_\_\_.
- I personally conducted an examination of \_\_\_\_\_ [name of individual] on \_\_\_\_\_ [date of examination] hereinafter referred to as 'the individual'.
- I further certify the individual's vision loss at the level of  permanent or  medically unlikely to return or improve, with or without glasses or assistive technology.

Date: \_\_\_\_\_ Examiner's Signature: \_\_\_\_\_

## INFORMATION TO THE EXAMINER

The individual named on this form is applying for or receiving public assistance based on visual impairment. Eligibility for assistance will be determined, in part, on the medical and visual information which you provide. Please complete the examiner's section of the visual disability examination report thoroughly and accurately.

By regulation, the applicant may choose to be examined by an ophthalmologist, an M.D. (or D.O.) skilled in diseases of the eye, or an optometrist. Also by regulation, the State Supervising Ophthalmologist reviews each report form and makes the final determination as to eligibility on the basis of vision.

"The examination shall be provided for by the Family Support Division without charge to the applicant and shall be paid as administrative expense." Section 209.080 RSMo (1961)

If there is any question the applicant meets the definition of blindness, the State Supervising Ophthalmologist will require a second examination to be made.

## STATE OPHTHALMOLOGIST RECOMMENDATIONS (SECTION BELOW FOR STATE SUPERVISING OPHTHALMOLOGIST USE ONLY)

### DECISION:

The individual:

- Is visually eligible
- Is not visually eligible
- Information is insufficient to establish eligibility. Obtain visual field examination

### RE-EXAMINATION:

- No longer eligible, explain improvement or reasoning in the Comments section below
- Five Years
- Waived
  - No useable vision in either eye.
  - Other, explain in Comments section below

COMMENTS: \_\_\_\_\_

If visual field exam included, State Ophthalmologist determines results as:

OD: \_\_\_\_\_ degrees

OS: \_\_\_\_\_ degrees

DATE REVIEWED BY STATE  
OPHTHALMOLOGIST: \_\_\_\_\_

STATE OPHTHALMOLOGIST  
SIGNATURE: \_\_\_\_\_