TALSHIR Medical Technologies

REVITALVISION by NEUROVISION

Examination form Low Vision

Date of Birth:	Patient name:
Patient Phone:	Patient address: _____ Patient email:

Baseline Examination

Present Rx

Please mark the correct box	Spectacles	CL	None

Current Spectacles Rx

		Sph	Cyl	Axis	Add
Distance	RE				
	LE				
Near	RE				
	LE				

Visual Acuity

		With current Rx	Without Rx
Distance	RE	20/	20/
	LE	20/	20/

Subjective Refraction

		Sph	Cyl	Axis
Distance	RE			
	LE			

BCVA Distance

		Decimal	Snellen	# letters missed
	RE		20/	
	LE		20/	

BCVA Near

		Snellen	Jaeger	# letters missed
	RE	20/		
	LE	20/		

Contrast Sensitivity	RE					Optional
FACT Sine Wave	LE					

Are there any Ocular disease? Yes/No

Please describe_____

Name of practitioner: _____ Signature: _____

Date of examination: _____

Clinics contact number: _____

Follow- up Examination Date: _____

		Decimal	Snellen	# letters missed
BCVA Distance	RE		20/	
	LE		20/	

		Snellen	Jaeger	# letters missed
BCVA Near				
	RE	20/		
	LE	20/		

Contrast Sensitivity	RE					
FACT Sine Wave	LE					
Optional						