A picture containing drawing, food

Description automatically generated

# OPHTHALMOLOGY EXAMINATION REPORT FORM

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **APPLICANT’S DETAILS MEDICAL IN CONFIDENCE** | | | | | | | |
| First Name | | Middle Name: | | Last Name | | License number | |
| Date of birth (dd/mm/yyyy) | | | | Sex: Male  Female | | Application Initial  Renewal | |
| State applied to: | | | | Medical certificate applied for | | | |
| **Consent to release medical information:** I hereby authorise the release of all information contained in this report and any or all attachments to the AME and, where necessary, to the medical assessor of the licensing authority, recognising that these documents or electronically stored data, are to be used for completion of a medical assessment and will become and remain the property of the licensing authority, providing that I or my physician may have access to them according to national law. Medical Confidentiality will be respected at all times. | | | | | | | |
| Date: / / | Signature of the applicant: | |  | | Signature of AME: | |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Examination Category** |  | **Ophthalmological history:** | **Current spectacles** | **SPH** | **CYL** | **AXIS** | **VA** |
| Initial |  |  |
| Renewal / Revalidation |  |  | Right eye |  |  |  |  |
| Special referral |  | Left eye |  |  |  |  |

**Spectacles Contactlenses**

**Clinical Examination**

**Visual acuity**

|  |  |  |  |
| --- | --- | --- | --- |
| Check each item | | **Normal** | **Abnormal** |
| Eyes, external & eyelids | |  |  |
| Eyes, Exterior (slit lamp, ophth.) | |  |  |
| Eye position and movements | |  |  |
| Visual fields (confrontation) | |  |  |
| Pupillary reflexes | |  |  |
| Fundi (Ophthalmoscopy) | |  |  |
| Convergence | cm |  |  |
| Accommodation | D |  |  |

***Distant vision at 5 m/6 m* Uncorrected**

|  |  |  |  |
| --- | --- | --- | --- |
| Right eye | Corrected to |  |  |
| Left eye | Corrected to |  |  |
| Both eyes | Corrected to |  |  |

***Intermediate vision at 1m***

**Uncorrected**

**Spectacles Contactlenses**

|  |  |  |  |
| --- | --- | --- | --- |
| Right eye | Corrected to |  |  |
| Left eye | Corrected to |  |  |
| Both eyes | Corrected to |  |  |

***Ocular muscle balance* (in prisme dioptres)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Distant at 5m/6m | | | Near at 30/50 cm | | |
| Ortho | | | Ortho | | |
| Eso | | | Eso | | |
| Exo | | | Exo | | |
| Hyper | | | Hyper | | |
| Cyclo | | | Cyclo | | |
| Tropia | Yes | No | Phoria | Yes **** | No |
| Fusional reserve testing Not performed Normal  Abnormal | | | | | |

***Colour perception***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Pseudo-isochrom | atic plates |  | Type: | | |
| No. of plates: |  |  | No. of errors: | | |
| Advanced colour Method: | perception | testing | indicated Yes | No |  |
| Colour SAFE | Colour UNSAFE | | | | |

|  |  |
| --- | --- |
| **Refractory Surgery** | Date: |
| Type of Surgery | Complication or side effect |
|  |  |

**Ophthalmic remarks and recommendations:**

{Remarks}:

|  |  |
| --- | --- |
| ***Near vision at 30–50 cm***  **Spectacles Contactlenses**  **Uncorrected** | |
| Right eye | Corrected to |  |  |
| Left eye | Corrected to |  |  |
| Both eyes | Corrected to |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Refraction*** | **Sph** | **Cylinder** | **Axis** | **Near (add)** |
| Right eye |  |  |  |  |
| Left eye |  |  |  |  |
| Actual refraction examined Spectacles prescription based | | | | |

**Contactlenses**

**Spectacles**

|  |  |
| --- | --- |
| Yes  No  Type: | Yes  No  Type: |

***Intra-ocular pressure***

|  |  |
| --- | --- |
| **Right (mmHg)** | **Left (mmHg)** |
| Method:  Normal  Abnormal | |

(322) **Examiner’s Declaration:**

|  |  |  |
| --- | --- | --- |
| I hereby certify that I/my AME Group have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly. | | |
| (323) **Place and date:** | **Ophth. Examiner’s Name & Address: (Block Capitals)** | **AME or Specialist Stamp & No.:** |
| **AME signature:** | Telephone No.: |
| Telefax No.: |