Occupational Therapy Low Vision Rehabilitation Evaluation

Form

Client:__________________________________________  DOB: __/___/___  Date: __/___/___
Address ___________________________________________ City __________
State____ Zip______
Telephone: ____________________  Referring Physician: ____________________________

_________________________________

Visual Acuity: Right Eye___________  Visual Acuity: Left Eye___________
Eye__________________
Eye Disease Diagnosis: _______________________________

<table>
<thead>
<tr>
<th></th>
<th>OT Evaluation of Visual Status if Not Available from Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA (Distance)</td>
<td>OT Evaluation of Visual Status if Not Available from Physician</td>
</tr>
<tr>
<td>Feinbloom Chart OD:</td>
<td>Feinbloom Chart OS:</td>
</tr>
<tr>
<td>VA (Near)</td>
<td>VA (Near) OS:</td>
</tr>
<tr>
<td>Reading Speed _____</td>
<td>Reading Speed ____</td>
</tr>
<tr>
<td>MNRead Chart</td>
<td>MNRead Chart</td>
</tr>
<tr>
<td></td>
<td>MARS Contrast Sensitivity Test (OU)</td>
</tr>
<tr>
<td>Eccentric Viewing Evaluation: Right Eye</td>
<td>Eccentric Viewing Evaluation: Right Eye</td>
</tr>
<tr>
<td>Evaluation of Scotoma (Clock face or Tangent Screen) OD</td>
<td>Evaluation of Scotoma (Clock face or Tangent Screen) OS</td>
</tr>
</tbody>
</table>

Veterans Affairs Low-Vision Visual Functioning Questionnaire (VA LV VFQ-
Background Information

How long have you experienced trouble seeing?
_________________________________________________

What is most difficult to see?
_________________________________________________

Have you ever had a low vision evaluation? Y / N
When: _________________________________
Where: ________________________________

Do you use any magnifiers or special glasses? Y / N
   Who gave them to you?
_________________________________________________

Any previous vision rehabilitation services? Y / N Describe.
_________________________________________________

Any previous Home Health Therapy?
_________________________________________________

Other Health Issues

__ Hearing loss  __Hearing Aid  __Diabetes  __Dialysis  __Stroke  __Hypertension  __Angina
__Cardiac problems  __Arthritis  __Respiratory

Medications:
_______________________________________________________________________
_______________________________________________________________________

Sensorimotor/Cognitive Function

<table>
<thead>
<tr>
<th>AROM UE:</th>
<th>AROM LE</th>
<th>Sensation:</th>
<th>Problem Solving:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROM UE:</td>
<td>PROM LE</td>
<td>Initiation:</td>
<td>Awareness:</td>
</tr>
<tr>
<td>Strength UE:</td>
<td>Strength LE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further Cognitive Evaluation Indicated?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Living Situation

Members of household and relationship to you:

________________________________________________________________________

How do you currently spend your time?

________________________________________________________________________

How did you spend it before your vision loss?

________________________________________________________________________

What activities are the most difficult for you since your vision decreased?

________________________________________________________________________

Do you receive assistance from anyone?

________________________________________________________________________

Food Preparation and Shopping

What food preparation do you do now?

________________________________________________________________________

What foods did you prepare before your vision loss?

________________________________________________________________________

Do you do your own grocery shopping? Y/N     Small trips      Full list

Describe assistance received with shopping

________________________________________________________________________

Do you have any difficulty completing the following tasks?

Describe any food preparation difficulties:

________________________________________________________________________

Cooking and Appliance Use

Appliances used in cooking: Stove      Oven      Microwave      Toaster oven      Broiler

Other: _________________________________________________________________

Do you have any problems cooking? Y/N

Visual _________________________________________________________________

Physical _______________________________________________________________
Table Techniques

Once food is prepared, do you have any difficulty finding food on the plate?

Do you have any difficulty when eating out?

Would you like to review any of the following table techniques?

<table>
<thead>
<tr>
<th>Technique</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locating technique</td>
<td></td>
</tr>
<tr>
<td>Identifying the contents of a plate of food</td>
<td></td>
</tr>
<tr>
<td>Cutting food with a knife and fork</td>
<td></td>
</tr>
<tr>
<td>Scooping food with a fork</td>
<td></td>
</tr>
<tr>
<td>Seasoning food</td>
<td></td>
</tr>
<tr>
<td>Carrying containers of food and liquids</td>
<td></td>
</tr>
<tr>
<td>Buffer technique</td>
<td></td>
</tr>
</tbody>
</table>

Other: _____________________________________________________

Communications

Do you have any problem:

<table>
<thead>
<tr>
<th>Task</th>
<th>Y/N</th>
<th>Method:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signing your name?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading any form of print?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Writing letters?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialing the operator in an emergency?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialing the telephone independently?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you aware of the directory assistance exemption?</td>
<td>Y / N</td>
<td></td>
</tr>
</tbody>
</table>

How do you manage:

<table>
<thead>
<tr>
<th>Task</th>
<th>Y/N</th>
<th>Difficulty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone/address directory:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paperwork/written records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying your money?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coins</td>
<td>Y/N</td>
<td>NA</td>
</tr>
<tr>
<td>Bills Y/N</td>
<td>NA</td>
<td>Difficulty:</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>-------------</td>
</tr>
<tr>
<td>Giving correct change when shopping? Y/N</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

Checking account

<table>
<thead>
<tr>
<th>Do you write out checks independently?</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>If not, who assists you in maintaining the account and paying bills?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you need a talking calculator?</th>
<th>Y/N</th>
</tr>
</thead>
</table>

Are you familiar with the Library of Congress recorded books program?

<table>
<thead>
<tr>
<th>Receiving</th>
<th>Not receiving</th>
<th>Not interested</th>
<th>Want to apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>If already participating, do you use EZ machine</td>
<td>Standard machine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_**Any problems with EZ machine?**_

---

### Home Management

**Identifying your keys?** Y/N

**Inserting the key in the lock and opening the door?** Y/N

**Identifying the time?** Y/N **Method:**

---

**Who does the majority of your house cleaning?** Self Other (specify):

---

**Do you find any of the following tasks difficult?**

- ___ Washing dishes  
- ___ Cleaning a surface  
- ___ Cleaning a refrigerator/stove  
- ___ Cleaning a floor (sweeping/vacuuming)

- ___ Making a bed  
- ___ Operating a thermostat  
- ___ Operating a television  
- ___ Operating a radio

**Other:**

---

### Clothing Management

Do you have any difficulty identifying clothing?

---

**Are there any items/colors that you find particularly difficult to identify?** Y/N

**Describe:**

---

**Do you do your own laundry?** Hand Machine Don't do
Operating the washing machine? Y/N       NA       Dryer? Y/N / NA
Do you have a need to sew? Y/N
Any Difficulties:

______________________________________________________________________
______________________________________________________________________

**Personal Care and Hygiene**

__ Do you have any difficulty locating and identifying items in your bathroom?
__ Do you experience problems taking a bath/shower independently and safely?
__ Do you feel you might need a grab bar to get in and out of the tub or a tub seat?

Do you have any difficulty when completing the following tasks?
__ Applying toothpaste __ Cleaning dentures __ Filing/cutting nails __ Using a spray can __
Shaving with a manual razor __ Shaving with an electric razor
Other:

______________________________________________________________________

**For persons with diabetes:**

Do you have a podiatrist or family member:
__ Routinely check your feet for cuts and sores
__ Assist with toenail care
Do you have difficulty identifying your medications?
Method used:

______________________________________________________________________

What technique do you use to keep track of the medications that you are supposed to take?

______________________________________________________________________
__ Any difficulty administering your medications? __ Splitting pills? __ Crushing pills? __
Measuring liquid medication? __ Self-injecting?
Does anyone help you with your medications? Y / N
Who ________________________________________________________________

Recommended adaptations:

______________________________________________________________________

**Hair Care**

__ Do you have any difficulty with hair care?
Cosmetics
Do you wear make-up?

Indoor Travel/O&M Screening
Are you able to find your way around your home without assistance?

Are you able to go up and down the stairs independently?

DIAGNOSIS

<table>
<thead>
<tr>
<th>Primary Impairment:</th>
<th>Diagnostic Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Impairment:</td>
<td>Diagnostic Code:</td>
</tr>
</tbody>
</table>

TREATMENT PLAN
Rehabilitation Potential:

Frequency: ___ per month, ___ units each visit, for a total estimate of visits

Duration/Projected Achievement Date:

Date Planned Established:

Recommended Nonoptical Adaptive Aids

Recommended Optical Aids
Recommended Rehab Techniques:
__ Eccentric Viewing
__ Scanning
__ Locating Techniques
__ Other:
___________________________________________________________________
___________________________________________________________________

Referrals:
___ O and M
___ Low Vision Exam
___ CCTV

TREATMENT GOALS:

<table>
<thead>
<tr>
<th>FUNCTIONAL LEVEL</th>
<th>GOAL</th>
</tr>
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<tbody>
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</tbody>
</table>
OT Signature: ________________________________ Date: __/___/___
Physician Signature __________________________ Date: __/___/___