CLINICAL LOW VISION EVALUATION INTAKE

TVI or CLVT:	Doctor: **Dr. Street**
	Date of Exam:
	Time of Exam:

STUDENT PROFILE		
Student:	Grade:	Reading Level:
Age:	DOB:	
Parent/Guardian:		
Address:		
Phone:		

VISION INFORMATION	
Date of Previous CLVE:	CLVE Doctor:
Primary Eye Doctor:	Date of Last Exam:
Diagnosis:	
Recent changes in vision:	
Description of student's use of vision including working distance:	

CONCERNS
Difficulties with school/activities of daily living/hobbies due to vision:
If working, job duties and visual difficulties related to tasks:
Mobility Concerns:

ADAPTATIONS (OPTICAL AND NON-OPTICAL)
Adaptations/ Low Vision Devices Currently Used:
Best Lighting:
Sun wear or glare control:

GOALS AND OBJECTIVES FOR EVALUATION (CURRENT/FUTURE)	
Student	
Parent	
TVI	
O&M Specialist	
Residence Hall Staff	