HO'OPONO SERVICES FOR THE BLIND
1901 Bachelot Street
Honolulu, HI 96817
Telephone: 586-5275/Fax: 586-5288
Mail outer Island reports to Division of Vocational Rehabilitation:
Hawaii Branch – 75 Aupuni Street, Hilo, HI 96720
Maui Branch – 54 South High Street, Room 309, Wailuku, HI 96793
Kauai Branch – 3060 Eiwa Street, Room 304, Lihue, HI 96766

Ref. date:_____
Dis. code:_____
Ref. code:_____

[ ] Eye Exam Report

[ ] Referral for Services (See reverse)

Date_____

Patient's Name_____ Soc. Sec. No. _____

Address _____ Telephone _____

B.D. _____ Sex _____ Onset Age _____ Occupation_____

Other Medical Problems_____

Contact Person/phone_____

Best Corrected Visual Acuity Distance Near	RX for Present Glasses
RE	RE Add:
LE	LE
☐ No Change With Correction	

Visual Fields (Please check appropriate blocks)

The widest diameter of visual field is:

[ ] 20 ^{o} or less (PLEASE ATTACH COPY OF VISUAL FIELDS)

[ ] Greater than 20 ^{o}

Visual Fields Not Done [ ]

Is this person legally blind? [ ] Yes [ ] No

……..

Diagnosis and Clinical Findings:

CHECK (✔) ☐ CATARACTS ☐ DIABETIC RETINOPATHY ☐ RETINITIS PIGMENTOSA

☐ GLAUCOMA ☐ MACULAR DEGENERATION

☐ OTHER: (Please Indicate)

Etiology: _____hereditary _____congenital _____traumatic _____infections
_____metabolic _____neoplastic _____toxic _____degenerative

Other_____

(over)

Functional limitations based on eye condition:

_____
_____
_____
_____

Prognosis/treatment:

The Condition is [ ] stable [ ] progressive [ ] temporary

Re-evaluation recommended in_____
_____
_____

In view of the findings in this case, is it important for other family members to have eye examinations?____ Yes ____ No

……...

Referral for Ho'opono Services:

____ Low Vision Clinic

____ Vocational Rehabilitation/Employment Services

____ Independent Living/Adjustment Services

____ White Cane

____ Counseling

____ Other _____

_____ _____
Examiner's Signature Date

Print Examiner's Name _____

(DO NOT COMPLETE THIS PORTION—FOR DEPARTMENT USE ONLY)

CERTICATION OF VISUAL IMPAIRMENT

Blindness _____ Approved

_____Disapproved Reason: _____

Partial Sight _____ Approved

_____ Disapproved Reason: _____

_____ _____
Ophthalmological Consultant Date