State of Hawaii
Department of Human Services
Division of Vocational Rehabilitation

HO`OPONO SERVICES FOR THE BLIND- EYE EXAM/REFERRAL FORM

DATE: _____

FIRST NAME:_____ LAST NAME: _____

DOB: _____ SSN: _____ GENDER: _____

ADDRESS: _____ CITY: _____

STATE: ____ ZIP CODE: _____ TELEPHONE: _____

OTHER MEDICAL CONDITIONS: _____

CONTACT PERSON: _____ CONTACT PHONE: _____

BEST CORRECTED VISUAL ACUITY (DISTANCE)

RIGHT EYE	LEFT EYE

VISUAL FIELDS (PLEASE CHECK THE APPROPRIATE BOX):

THE WIDEST DIAMETER OF VISUAL FIELD IS:

☐ 20° OR LESS (PLEASE ATTACH A COPY OF THE VISUAL FIELDS EXAMINATION)

☐ GREATER THAN 20° ☐ VISUAL FIELDS NOT DONE

IS THIS INDIVIDUAL LEGALLY BLIND? ☐ YES ☐ NO

DIAGNOSIS AND CLINICAL FINDINGS (CHECK ALL THAT APPLY):

☐ MACULAR DEGENERATION ☐ DIABETIC RETINOPATHY ☐ GLAUCOMA

☐ RETINITIS PIGMENTOSA ☐ CATARACTS

☐ OTHER (PLEASE INDICATE): _____

ETIOLOGY: ☐ HEREDITARY ☐ CONGENITAL ☐ INFECTIOUS ☐ TRAUMATIC ☐ TOXIC

☐ METABOLIC ☐ DEGENERATIVE ☐ DIABETES ☐ OTHER: _____

REFERRAL FOR HO`OPONO SERVICES (CHECK ALL THAT APPLY):

- ☐ LOW VISION CLINIC
- ☐ VOCATIONAL REHABILITATION/EMPLOYMENT SERVICES
- ☐ INDEPENDENT LIVING/ADJUSTMENT TO BLINDNESS SERVICES
- ☐ OLDER INDIVIDUALS WHO ARE BLIND SERVICES
- ☐ WHITE CANE/MOBILITY TRAINING
- ☐ OTHER: _____

_____ _____
EXAMINER'S SIGNATURE DATE

_____
PRINT EXAMINER'S NAME

MAIL: 1901 BACHELOT STREET HONOLULU, HAWAII 96817

CALL: (808)586-5269 MAIN LINE

FAX: (808)586-5288

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

CERTICATION OF VISUAL IMPAIRMENT

BLINDNESS ☐ APPROVED

☐ DISAPPROVED REASON: _____

PARTIAL SIGHT ☐ APPROVED

☐ DISAPPROVED REASON: _____

_____ _____
OPHTHALMOLOGICAL CONSULTANT DATE