



Low vision medical certificate

Please retain a copy for your own records

SURNAME: FIRST NAME

ADDRESS: Post Code _____

Date of Birth: ___/___/___ Phone: Male Female

Date of certificate: ___/___/___ Date last exam: ___/___/___ DVA Gold Card

Is this person legally blind? Yes / No
 Is the vision capable of improvement? Yes / No
 Is there any claim for insurance/compensation pending? Yes / No Please attach details

Please order and rank the eye condition contributing to vision loss for each eye: 1= primary cause, 2= second most contributory, 3= next most contributory.

	Right eye	Date of onset	Left eye	Date of onset
Age – related macular degeneration (wet/scar)		___/___/___		___/___/___
Age – related macular degeneration (dry/atrophy)		___/___/___		___/___/___
Diabetic retinopathy		___/___/___		___/___/___
Retinal vein occlusion (Branch)		___/___/___		___/___/___
Retinal vein occlusion (Central)		___/___/___		___/___/___
Retinal artery occlusion		___/___/___		___/___/___
Retinitis Pigmentosa		___/___/___		___/___/___
Glaucoma		___/___/___		___/___/___
Optic neuropathy		___/___/___		___/___/___
Corneal opacity		___/___/___		___/___/___
Cataract		___/___/___		___/___/___
Other.....		___/___/___		___/___/___

	Right eye	Left eye	Both eyes
Best corrected distance visual acuity	___/___	___/___	___/___
Visual field in degrees diameter or describe field loss. Please provide a copy of the most recent field test.	___°	___°	

Any other relevant information:

Related ocular or general medical conditions: Please tick boxes

- | | |
|--|--|
| <input type="checkbox"/> Ischaemic heart disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Hemi/paraplegia |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Cerebrovascular disease | <input type="checkbox"/> Pulmonary disease |
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Renal disease |
| <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Other..... |

NAME (PRINT): QUALIFICATIONS:

ADDRESS:

SIGNATURE:

Consent for registration with the Association for the Blind of Western Australia

I would like to be registered with the Association for the Blind of Western Australia. I have been given and understand the information sheet about the Association for the Blind of Western Australia, and their services. I understand the Association for the Blind of Western Australia will contact me about their services.

I agree that the details on '**Low Vision Medical Certificate**' will be provided to the Association for the Blind of Western Australia on the understanding that all information provided is treated as confidential.

I agree that my information may be used by the Association for the Blind of Western Australia for research aimed at supporting and benefiting people who are blind or have vision impairment in Western Australia.

I understand that I can withdraw my consent for my personal information to be used for research by contacting the Association for the Blind of Western Australia.

Signed.....

Date __ / __ / __

(Parent/Guardian if person is under 16 years of age)

Name.....

(Parent/Guardian if person is under 16 years of age)

Please forward a copy to:

Association for the Blind of WA,
61 Kitchener Avenue, Victoria Park WA 6100.

PO Box 101, WA 6979

Phone: (08) 9311 8202. Fax: (08) 93618696

www.guidedogswa.com.au