NovaVision® EYE EXAMINATION FORM

PLEASE PRESENT TO YOUR EYE DOCTOR BEFORE YOUR EXAM.
SEND THIS FORM, CANDIDATE INFORMATION FORM & VISUAL FIELD RESULTS TO NOVAVISION TO COMMENCE VRT.

Dear Doctor: *Your patient is interested in initiating **V**ision **R**estoration **T**herapy (VRT) for the treatment of neurological visual field loss predominantly resulting from stroke or TBI. To qualify, each VRT candidate must undergo an eye examination, including the tests listed below and a visual field examination, which will assist with preparing and interpreting the therapy regimen.*

Patient Name _____ **D.O.B.** _____

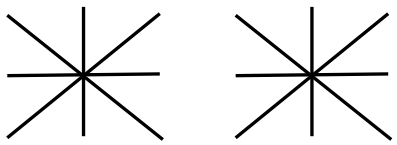
Patient Phone _____ **Exam Date**_____

Rx to be used for VRT: (BCVA for Near work) **BCVA (better seeing eye must be ≥20/200)**

OD: Sph_____ Cyl + / - _____ Axis_____ Add_____ Dist_____ Near_____
OS: Sph_____ Cyl + / - _____ Axis_____ Add_____ Dist_____ Near_____

Make hash-mark at point of any gaze limitation or check none

OD OS



☐ None

Test	Results (Check yes if normal)	Yes	No	If no, please explain
Tropia/Phoria:	Normal - None present/functionally significant	☐	☐	_____
Convergence:	Normal - Can converge/maintain fusion at 12 inches	☐	☐	_____
Nystagmus:	Normal - None in primary gaze/upon convergence	☐	☐	_____
Color Vision:	Normal - Views all color plates	☐	☐	_____

Please list any pathology that may affect this patient's visual function.

Anterior Segment: _____

Posterior Segment: _____

Visual Field Test Requirement: Perform your standard central 10°, 24° or 30° threshold or other automated visual field test (use C-30 or N-30 for FDT) and **submit the results** to document the field defect and certify the patient is able to perform VRT. The 10-2 threshold strategy may best detect field improvement from VRT.

Examining Doctor (Signature) _____ Lic# _____State _____

Examining Doctor (Print) _____ Office Tel. _____