NovaVision®

CANDIDATE INFORMATION FORM

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

Please Check ☑: Vision Restoration Therapy (VRT) Inclusion Criteria

- ☐ Has neurological visual field defect involving central 30 degrees
- ☐ Has best corrected visual acuity of at least 20/200 in one eye
- ☐ Able to sit upright for visual field test type activity for 15-30 minutes
- ☐ Able to manually click computer mouse or response button
- ☐ No significant attentional, cognitive, or behavioral dysfunction

If a patient does not meet criteria, refer to a VRT Advanced Care Center or call NovaVision for consideration. Dementia, severe aphasia, and photosensitive seizure disorder are contraindications for VRT.

Please Circle and Complete: Therapy Optimization

Cause of Visual Field Loss:	CVA Traumatic Brain Injury Other CNS Lesion: ____________________
Date Occurred:	______________________
Current Health Problems:	DM Depression Aphasia Hemiparesis Memory Impairment None
Current Living Situation:	With Family/Other Has Prof. Caregiver Assisted Living Alone/Independent
Computer Experience:	Advanced Intermediate Some Familiarity Beginner

PRESCRIPTION

Dr. Name ________________________
Lic# __________________ **State** ______
Address ________________________
Phone __________________________

Name: ____ Date: ____________________

Address: ____

Phone: ____________________________ Date of Birth: _________________________________

Rx: **Vision Restoration Therapy (VRT)**

☐ **180 days/6 months**

☐ **Additional 90 days/3 Months**

Contact: NovaVision Patient Services at 1.888.205.0800
Fax to: 1.561.620.2546

Physician Signature: ____

Fax to NovaVision HIPAA Secure Line: 1.561.620.2546

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 for the treatment of neurological visual field loss. VRT is a computer-based, research proven, visual therapy regimen that triggers neuroplastic repair of visual function within the brain and is offered by many major eye, rehabilitation, and neurology centers. 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.** ________________

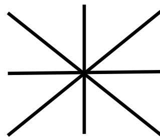
Patient Phone ________________________________ **Exam Date**______________

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

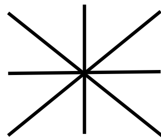
OD: Sph___________ Cyl + / - _________ Axis_________ Add__________ Dist_____ Near______
OS: Sph___________ Cyl + / - _________ Axis_________ Add__________ Dist_____ Near______

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# enter license #.State enter state.

Examining Doctor (Print) Click here to enter Doctor's name Office Tel. Click here to enter number

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