CONFIDENTIAL REPORT OF BLINDNESS OR VISUAL IMPAIRMENT

State Form 48126 (R2 / 9-04) / BVIS 0007

BUREAU OF BLIND AND VISUALLY IMPAIRED SERVICES

THIS STATE AGENCY IS REQUESTING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER IN ORDER TO EXPEDITE PROCESSING OF YOUR APPLICATION. DISCLOSURE IS VOLUNTARY AND YOU WILL NOT BE PENALIZED FOR FAILURE TO DISCLOSE YOUR S.S.N. PER IC 4-1-8. **Confidential per IC 25-24-1.**

PLEASE TYPE OR PRINT

Name of patient (*last, first, middle initial*)			Social Security number *
Street address			County
Telephone number ( )	City		ZIP code (*5 digits plus four*) –
Date of birth (*month, day, year*)	Age	Date of exam (*month, day, year*)	Sex (*check one*) ☐ Male ☐ Female
Race / ethnicity (*check one*): ☐ White ☐ Black ☐ Hispanic ☐ Native American ☐ Asian / Pacific ☐ Multiracial ☐ Other ☐ Unknown			
Is patient diabetic? (*check one*) ☐ Yes ☐ No	If Yes, what type? (*check one*) ☐ Type 1 ☐ Type 2 ☐ Unknown		

This is to certify that I examined the above person and the following is the result of visual testing with **best correction in the better eye**.	Date of exam (*month, day, year*)

VISUAL ACUITY		AND / OR	VISUAL FIELD
Check all that apply:			Check all that apply:
☐ 20/60 - 20/180 (*visually impaired*)	☐ Light projection only		☐ 45-70° in diameter (*impaired*)
☐ 20/200 - 20/2000 (*legally blind*)	☐ Light perception only		☐ 21-44° in diameter (*impaired 2*)
☐ 20/2000 (*motion perception*)	☐ No light perception		☐ 20° in diameter (*legally blind*)

DIAGNOSIS

Check all that apply:

☐ Cataracts ☐ Eye injury ☐ Macular degeneration

☐ Diabetic retinopathy ☐ Glaucoma ☐ Retinitis pigmentosis

☐ Other: _____

_____

Please add comments regarding other significant information relating to visual status which may impact education, employment, and/or other activities:

- Patient given information on available services through the Blind & Visually Impaired Services and/or Vocational Rehabilitation; Division of Disability, Aging, & Rehabilitation Services; Indiana Family and Social Services Administration? ☐ Yes ☐ No
- Patient refused information? ☐ Yes ☐ No

Printed name of optometrist or physician	
Name of practice / university	Telephone number ( )
Signature of optometrist or physician	Date (*month, day, year*)

Indiana code (IC) 16-40-2-1 *- Persons required to report. Each physician holding an unlimited license to practice medicine, or optometrist licensed under IC 25-24-1,* ***shall report in writing, on forms prescribed by Blind and Visually Impaired Services, not more than ten (10) days after diagnosis****, to the state department the name, age, and address of each person diagnosed by the physician or optometrist as being blind (as defined under 42 U.S.C. 416(i)) or having visual impairment of a degree to interfere with the person's functioning in school, employment, or other activities of daily living.* ***IC 16-40-2-3*** *- Confidentiality. All reports filed under this chapter shall be kept confidential and used solely for the purpose of determining the eligibility of the individuals for assistance or rehabilitation.* ***IC 16-40-2-7*** *- Failure to report. A person required to make a report of blindness under this chapter who fails to do so commits a Class C infraction.*

Mail completed form to: **Blind and Visually Impaired Services**
402 West Washington St. MS22, P.O. Box 7083
Indianapolis, IN 46207-7083
Toll Free telephone number 1-877-241-8144