CONFIDENTIAL REPORT OF BLINDNESS OR VISUAL IMPAIRMENT

State Form 48126 (R3 / 11-11)
DIVISION OF DISABILITY AND REHABILITATIVE SERVICES
BLIND AND VISUALLY IMPAIRED SERVICES

Mail completed form to:
BLIND AND VISUALLY IMPAIRED SERVICES
402 West Washington Street, MS22
P.O. Box 7083
Indianapolis, IN 46207-7083
Telephone: 1-877-241-8144

PLEASE TYPE OR PRINT

PATIENT INFORMATION

Name of patient (*last, first, middle*)		
Street address (*number and street*)	County	
City	ZIP code (*5 digits plus four*) –	Telephone number ( )
Date of birth (*month, day, year*)	Age	Sex (*check one*) ☐ Male ☐ Female

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

INFORMATION ON AVAILABLE SERVICES *(Check those that apply.)*

☐ **Yes**, the patient has been given information regarding the services available through the Indiana Blind and Visually Impaired Services program and/or organizations that serve the blind and visually impaired.

☐ **No**, the patient has refused to receive any information regarding the services available through the Indiana Blind and Visually Impaired Services program or other organizations.

☐ **Yes**, the patient would like to be contacted by an Indiana State agency or an organization serving the blind and visually impaired (working with the State) regarding available services.

☐ **No**, the patient would not like to be contacted by an Indiana State agency or other organizations serving the blind and visually impaired regarding available services.

If the patient said **No** to being contacted, please have the patient sign below or the physician or optometrist may sign indicating that the patient has verbally requested not to be contacted.

Signature of patient or signature of provider indicating patient's verbal refusal to be contacted.	Date (*month, day, year*)

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

Authority: *Indiana Code 12-12-9-1 requires a physician holding an unlimited license to practice medicine or an optometrist licensed under IC 25-24-1 to report in writing, on forms prescribed by the Secretary of the Indiana Family and Social Services Administration (the parent organization of the Blind and Visually Impaired Services program), the name, age, and address of each person diagnosed as 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. Under IC 12-12-9-7, a person required to make this report commits a Class C infraction for failing to do so.*