**STATE OF ALASKA**
**DEPARTMENT OF HEALTH**
**REVIEW REPORT ON AID TO THE BLIND**

Patient's Name _____ Birth Date _____

Mailing Address _____

Please attach to this form a current medical evaluation regarding this patient. (A letter may be preferable to the Community Physical Exam because it can be more informative.)

In your accompanying medical information please state:

1. Whether this patient is blind;
2. Explain the nature and severity of the vision impairment;
3. How the impairment affects this person's life.

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Has this person been seen by a specialist recently regarding vision problems (i.e. ophthalmologist, optometrist)?

_____ _____

Printed name of specialist Specialty

_____

Address of specialist

The term "Blindness" in the Aid to the Blind Program means that the patient has central visual acuity of 20/200 or less in the better eye with the use of a corrective lens, or that he suffers from tunnel vision in one or both eyes to the extent that his field of vision is no greater than 20 degrees.

Is patient considered blind under this definition? ☐ Yes ☐ No

Measurement of central visual acuity: Right _____ Left _____

Angle of field of vision: _____

_____

Printed name of M.D. Type of practice
(Family practice, ophthalmologist, etc.)

_____

Address Signature

**NOTE:**

Should the person not qualify as being blind but is in need of assistance while recuperating, there may be other programs available.

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**FOR STATE USE ONLY**

Decision reached: ☐ Approved

☐ Denied

_____
Medical Practice Review Officer

_____
Date

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