



# Family Works

5604 Medical Circle  
Madison, Wisconsin 53719

## Optical Exam

Name of Client: \_\_\_\_\_

Foster Home Placement: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Acuity without Correction: O.D. \_\_\_\_/\_\_\_\_ O.S. \_\_\_\_/\_\_\_\_

Acuity with Correction: O.D. \_\_\_\_/\_\_\_\_ O.S. \_\_\_\_/\_\_\_\_

Present Prescription: D. \_\_\_\_\_ S. \_\_\_\_\_

Condition of Fundi (drawing or comments):

Test for Glaucoma: Negative \_\_\_\_\_ Positive \_\_\_\_\_

Signature of Optometrist/Ophthalmologist: \_\_\_\_\_

Clinic Name \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_