

PHYSICIAN'S REPORT ON EYE INJURIES

Refer to Ind. 80.26, Loss of vision; determination

**Department of Workforce Development
Worker's Compensation Division**
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Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

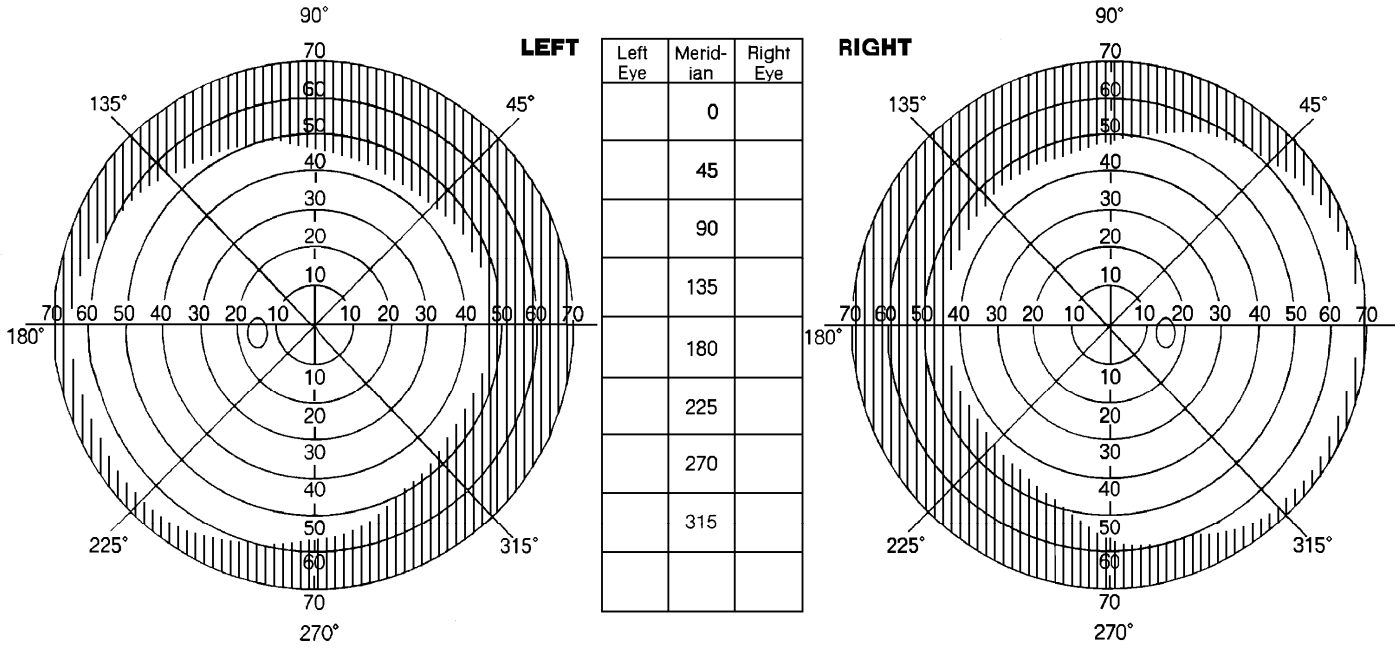
PATIENT	WC Claim Number		Employee Name																								
	Social Security Number		Employee Address																								
HISTORY	Injury Date		Employer Name			Insurance Company Name																					
	Date of First Treatment			Date of Last Treatment or Exam			Which eye is injured? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both																				
	If only one eye is injured, is the other eye affected? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain																										
NATURE OF INJURY AND DIAGNOSIS	Please be as detailed as possible																										
	Is physical condition of the eyes stationary? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:			1) Did cataract form as a result of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			Danger of further impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:																				
	Have all adequate and reasonable operations been attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No			2) If cataract formed, was lens removed? <input type="checkbox"/> Yes <input type="checkbox"/> No			3) Has there been a surgical implant of lens? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
CENTRAL VISUAL READINGS	Distance → Use Snellen test letters or characters up to 20/800.																										
	Near → Use AMA Reading Card up to 14/560.																										
	IMPORTANT: PLEASE FILL OUT EACH LINE COMPLETELY FOR EACH EYE	After Injury				Pre-existing before injury, including presbyopia and other conditions clearly not the result of the injury.																					
		Without Correction		With Correction		Without Correction		With Correction																			
Distance		Near	Distance	Near	Distance	Near	Distance	Near																			
	Right					Right																					
	Left					Left																					
PRIOR DISABILITY	Did the employee wear glasses for pre-existing subnormal vision? <input type="checkbox"/> Yes <input type="checkbox"/> No																										
	Is there a record or positive indication of pre-existing subnormal vision? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Explain:																										
	Is the remaining impairment due to the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:																										
BINOCULAR VISION	Is there absence of useful binocular vision? <input type="checkbox"/> Yes <input type="checkbox"/> No																										
	Explain cause: If a result of the injury, what is the percentage of additional permanent disability?																										
	Is there any diplopia present? <input type="checkbox"/> Yes <input type="checkbox"/> No																										
	If yes, this should be plotted in the chart at the right by placing an X in each square in which diplopia is found. The test is to be made with any industrially useful correction applied.																										
Was such correction used? <input type="checkbox"/> Yes <input type="checkbox"/> No																											
Industrial Motor Field Chart																											
<table border="1" style="width: 100%; height: 100%;"> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> </table>																											

FIELD VISION

Field vision taken without correction if possible using a white test object which subtends one degree and a standard perimeter with a radius of 12.9 inches (330 mm). The test object shall measure 0.223 inches (5.8 mm).

Is there any loss of the field of vision? Yes No Is it the result of the injury? Yes No

If so, indicate on the charts and table below. **Sketch impaired area. Sketch areas of any scotomata.**



When did the last trace of inflammation disappear from the eye?

Date able to return to work:

OTHER FUNCTIONS

Certain ocular disabilities are not covered in the foregoing sections, such as disturbance of accommodation, of color vision, of adaptation to light and dark, metamorphosia, entropion, ectropion, lagophthalmos, epiphora, and muscle disturbances not included under diplopia. Is any such disability present? **If so, explain under "Remarks" below, stating whether it results from the injury, what it is, which eye, or whether both eyes are affected, and your percentage estimate of the impairment of the eye or eyes for industrial use.**

Remarks:

Doctor Signature: _____ Date Signed: _____
 (Required in doctor's own handwriting)

Address: