רשות התעופה האזרחית
Civil Aviation Authority

Report of Eye Evaluation

CAAI Form No. Eye 1. Date:

2a. NAME OF AIRMAN *(Last, First, Middle)*	2b. DATE OF BIRTH	2c. GENDER *(M or F)*

3. ADDRESS OF AIRMAN *(No, Street, City, State, Postal Code)*

4. HISTORY – Record pertinent history, past and present, concerting general health and visual problems

5. **HETEROPHORIA** – Record phorias, in prism diopters, with and without best lens correction in place.

	(1) AT 20 FEET				(2) AT 18 INCHES	
A. WITHOUT CORRECTION	EXO.	ESO.	HYPER.	EXO.	ESO.	HYPER
A. WITh CORRECTION *(If any)*	(1) AT 20 FEET				(2) AT 18 INCHES	
	EXO.	ESO.	HYPER.	EXO.	ESO.	HYPER

6. FUSION – Estimate fusion ability and state methods used in examination. (Red lens, etc.)

7. PUPILS – Statement of relative size and reaction of the pupils to accommodation and light, direct and con sensual.

8. VISUAL FIELDS – Record results and type of test performed. (Attach field charts, *if used*).

9. OPHTHALMOSCOPIC – Describe any varions from normal in *either eye* on funduscopic examination.

10. SLIT LAMP – Record results of slit lamp examination of each eye where indicated.

11. INTRAOCULAR PRESSURE – Record results and methods used.

A. METHOD USED	O.D.	O.S.

12. VISUAL ACUITY *(Use Snellen Equivalents)*			LENSES USED	CORRECTED VISUAL ACUITY			
A. DISTANT VISION	TEST METHOD	UNCORRECTED	CONTACT LENSES	O.D.	O.S.	O.U.	
		O.D.		O.S.	O.U.		
		GLASSES					
A. NEAR VISION (16 INCHES)	TEST METHOD	UNCORRECTED	CONTACT LENSES	O.D.	O.S.	O.U.	
		O.D.		O.S.	O.U.		
		GLASSES					
A. INTERMEDIATE VISION	TEST METHOD	UNCORRECTED	CONTACT LENSES	O.D.	O.S.	O.U.	
		O.D.		O.S.	O.U.		
		GLASSES					

NOTE – If contact lenses are used, corrected near visual acuity should be determined while these lenses are worn, indicate if the contact lenses used *(if any)* were bifocal.

13. PRESENT PRESCRIPTION *(Sphere, cylinder, axis)*			
A. CONTACT LENSES		B. GLASSES	
O.D.	O.S.	O.D.	O.S.
IF CONTACT LENSES ARE NOT USED, OMIT ITEMS 14-19			
14. TYPE OF LENSES (Corneal, scleral, lenticular, single-cut, *bifocal,* toric, non-rotating, special shape, etc.)			
15. EXAMINATION FREQUENCY – Indicate frequency of periodic follow-up examination.			
16. SYMPTOMS OR ABNORMAL CONDITIONS – Note any lacrimation, photophobia, loss of lens, or evidence of corneal injury or edema, etc., requiring treatment and/or interruption of contact lens wearing. State results of slit lamp or biomicroscopic examination of cornea.			
17. PROFESSIONAL EVALUATION – Indicate your professional opinion and any other comment or additional observations.			
18a. TYPED NAME AND ADDRESS OF EYE SPECIALIST		18b. SIGNATURE OF EYE SPECIALIST	