SPECIAL EYE REPORT

1. Name		2. CAA Client No.	
3. Postal Address		4. Date of Birth	

5. Certificate(s) applied for

Class 1 ☐ Class 2 ☐ Class 3 ☐

6. Applicant's Signature: (To be signed in front of examiner).

Date / /

7. HISTORY/FAMILY HISTORY of relevant diseases (e.g. diabetes), vision problem (e.g. glaucoma), or surgery (e.g. refractive).

8. VISUAL ACUITY

	Distance (6 m) Class 1 and 3: each 6/9, Binocular 6/6 Class 2: each 6/12, Binocular 6/9			**Intermediate** (100 cm) Class 1 and 3: std N14			**Near** (30-50 cm) Class 1, 2 and 3 std N5		
	Right	Left	Both	Right	Left	Both	Right	Left	Both
Uncorrected	6/			N			N		
with Main Correction	6/			N			N		
Standby Correction	6/			N			N		

9. PRESCRIPTION

			Distance Right	Left			**Intermediate** Right	Left			**Near** Right	Left
Main Correction Please specify type of correction used	Main	DS			Main	DS			Main	DS		
		DC				DC				DC		
		Ax				Ax				Ax		
Standby Correction Please specify type of correction used	Standby	DS			Standby	DS			Standby	DS		
		DC				DC				DC		
		Ax				Ax				Ax		

10. CONTACT LENSES (if used)

a. Type?

b. How long in use?

c. Detail any contact lens associated pathology

d. Well tolerated? (e.g. long haul flying) Yes ☐ No ☐

e. Fit and Power adequate? Yes ☐ No ☐

11. COLOUR PERCEPTION – Standard ISHIHARA 24-plate book.

a. Are the first 17 plates read with ONE error or less? Yes ☐ No ☐
Record errors as an, '**X**' in the appropriate box.

b. If **NO** please provide a full report.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17

12. MUSCLE BALANCE

			Normal	**If abnormal please specify dioptres and provide fusional reserves.**
a. Cover Test			☐	
b. Distance	Exo	<12 △	☐	
	Eso	<6 △	☐	
	Hyper	<1 △	☐	
c. Near	Exo	<12 △	☐	
	Eso	<6 △	☐	
	Hyper	<1 △	☐	

13. OTHER TESTS

	Normal	**If abnormal please specify**
a. Binocular single vision	☐	
b. Fundi, media and corneas	☐	
c. Visual fields by confrontation	☐	
d. Intraocular pressure/optic nerve	☐	
e. Contrast sensitivity/glare/ haze **must** be checked with all refractive surgery. (Loss of VA in glare abnormal if more than 2 lines).	☐	

14. ADDITIONAL REMARKS (Comments or further action recommended?)

15. Print Examiner's Name and Address
(Practice Stamp Preferred)

Telephone Number

Facsimile Number

16. Client's ID: Indicate the type of photographic ID sighted, serial number and expiry date.

17. Examiner's Declaration: I hereby certify that I personally identified and examined the applicant named on this medical report and that this report, with any attached notes, embodies my examination completely and correctly.

Examiner signature Date / /