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