vsp eyes of hope

Eye Exam Form

Date ____ / ____ / ____
Month Day Year

Name _____ **Pronouns (optional)** _____
First MI Last

Legal Name (If Different) _____ **Age** _____ **Date of Birth** _____
First MI Last Month Day Year

PREVIOUS RX Wears: ❑ Full Time ❑ Distance Only ❑ Near Only

	Sph	Cyl	Axis	Prism	Add
OD					
OS					

AUTO REFRACTION ❑ Unable to Test

	Sph	Cyl	Axis
OD			
OS			

TONOMETRY

OD	OS	Time	PD
		AM / PM	

VA W/RX **VA W/O RX**

	Dist	Near	Dist	Near
OD	/	/	/	/
OS	/	/	/	/
OU	/	/	/	/

Color Vision: ____/____ correct ❑ Unable to Test

Stereopsis: ____/____ correct ❑ Unable to Test

COVER TEST **Distance** _____ **Near** _____

PUPILS _____

Perrla ❑

HEALTH HISTORY (SEE PATIENT HISTORY QUESTIONNAIRE)

Medications: _____

Allergies: _____

SUBJ. REFRACTION Add

OD _____ 20/ ____ _____ 20/ ____

OS _____ 20/ ____ _____ 20/ ____

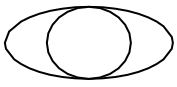
Phorias _____

CNFRT VISUAL FIELDS

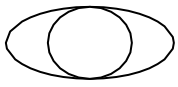
OD _____ Full ❑

OS _____ Restricted ❑

OCULAR HEALTH

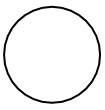


OD

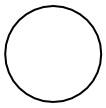


OS

OPHTHALMOSCOPE



OD



OS

	OD	OS
C/D		
A/V Lens	❑ Clear	❑ Clear
Reflex	❑Present	❑Present

DILATION _____ Time _____ AM / PM

DIAGNOSIS _____ **TREATMENT PLAN** _____

❑ Myopia ❑ Hyperopia ❑ Astigmia ❑ Presbyopia ❑ High Cholesterol ❑ Hypertension

❑ Diabetic ❑ Diabetic Retinopathy ❑ Glaucoma ❑ Macular Degeneration ❑ Corneal Arcus ❑ None

Doctor's Name: _____ Doctor's Signature: _____

Doctor's Notes: _____

FINAL RX ❑ Full-Time Wear ❑ Distance ❑ Near

	Sph	Cyl	Axis	Prism	Add
OD					
OS					

REFERRAL TO:

❑ Optometrist ❑ Primary Care Physician

❑ Ophthalmologist ❑ Other _____

REFERRAL REASON ❑ Cataracts ❑ Glaucoma ❑ AMD ❑ Diabetic Risk ❑ Hypertension Risk ❑ Other (explain)

EXPLANATION _____

vsp eyes of hope

Lab Order Form

Name _____ **Date of Birth** _____
First MI Last Month Day Year

Best Phone Number (_____)_____-_____ **Sex/Gender*:** ☐ Female ☐ Male
Area Code Phone Number

Pronouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Specify:_____

Street Address _____ **Apt/Suite #** _____

City _____ **State** _____ **ZIP Code** _____

THE FOLLOWING SECTION IS TO BE COMPLETED BY VSP VISION STAFF MEMBERS. PLEASE PRINT CLEARLY.

EVENT

_____ _____ | G | C | | | | | | | | |
Date of Service **Event Name** **Gift Certificate #**

_____
Doctor's Name

EXAM

Dilation: ☐ Yes ☐ No **EHM Diagnosis:** ☐ Diabetes ☐ Diabetic Retinopathy ☐ Hypertension ☐ High Cholesterol ☐ None

LENSES

Lab: ☐ VSPOne Columbus ☐ Odyssee IOF ☐ Eyenstein IOF ☐ SeeZar IOF ☐ Other _____

Lens Type:
☐ Single Vision ☐ Bifocal (Flat Top 28) ☐ Trifocal (7 x 28)

Materials:
☐ Polycarbonate
☐ Plastic

RX:	Sphere	Cylinder	Axis	Prism	Add
Right					
Left					

Seg Ht:^

^Bottom of Frame

PD: Distant Near

Binocular

FRAME

Supplier: Dr Supplied – To Come **Model:** _____

Manuf.: Marchon/Altair **Eye Size:** 52 **DBL:** 18 **Temple:** 145

Color: _____ **Material:** ☐ Metal ☐ Plastic/Zyl

NOTES

_____

_____

_____

*VSP Vision recognizes all gender identities, but the system used to order your glasses requires us to fill in either male or female. This information won't be used for any other purpose.

Patient History Questionnaire

The information on this form will be used by the doctor during your eye exam. VSP Vision™ Eyes of Hope® provides equal care to all individuals, regardless of age, race, ethnicity, physical ability or attributes, sexual orientation, gender identity, gender expression, and any other protected characteristic.

Name_____ **Today's Date**_____
First MI Last

Pronouns (optional)_____ **Phone Number** (_____)_____-_____
Area Code Phone Number

Race/Ethnicity (check all that apply) ☐ African-American/Black ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other _____

Preferred Spoken Language_____

Emergency Contact Name_____ **Phone Number**_____
Area Code + Phone

Personal Eye Health Information

Do you have any eye conditions or problems? ☐ Yes ☐ No What kind? _____

Have you ever had any eye surgery? ☐ Yes ☐ No Type_____ Date_____

Have you ever had an eye injury? ☐ Yes ☐ No What kind?_____ Eye? L / R Date _____

Do you have any of the following? (Check all that apply.)

☐ Blurred Vision ☐ Cataracts ☐ Dry Eyes ☐ Glaucoma

☐ Macular Degeneration ☐ Retinopathy ☐ Retinal Detachment

Do you wear glasses? ☐ Yes ☐ No Do you wear contact lenses? ☐ Yes ☐ No Type _____

Personal Medical Information

Have you ever been told by a health professional that you have any of the following? (Check all that apply.)

☐ Diabetes/Sugar–date of onset: _____ ☐ Metabolic Syndrome

☐ High Blood Pressure ☐ High Cholesterol ☐ HIV/AIDS

Do you have any other health conditions?

☐ Yes – Please explain _____

☐ No

List any allergies to any medications or drops _____

Are you taking any medications?

☐ Yes – Please list _____

☐ No

vsp eyes of hope

Media Release and Consent for Care

I, the undersigned, authorize Vision Service Plan, dba VSP Vision™ ("VSP"), and all its lines of business, subsidiaries and affiliates, as well as its/their directors, officers, employees, agents, representatives and/or contractors to release and discuss information regarding my treatment, medical condition, or related topics, as well as that of the individual to whom I provide guardianship.

I authorize and give permission to VSP to use, reuse, distribute, publish, and republish, in whole or part, my and/or their testimonial(s), statement(s), and/or image(s) and information related to the diagnosis, treatment and healthcare services provided or to be provided, and which identifies my and/or their first name and other deidentified personal information in any electronic, broadcast, printed and/or other form of medium, including all websites, blog and social media platforms maintained, operated by and/or affiliated with VSP in conjunction with its business related publicity and/or media relations activities.

- I understand VSP may receive direct or indirect financial remuneration in connection with the use or disclosure of my deidentified information/images from a third party due to marketing.
- I understand I will not receive any financial compensation for the use and disclosure of my information/image.
- I understand I have the right to revoke this Authorization up until a reasonable time before my deidentified personal information/image is used by providing written notice to VSP.
- I understand if I revoke this Authorization, my information may no longer be used or released for the reasons covered by this Authorization. However, I understand that any disclosure or publication made prior to a revocation may remain in public domain.
- I release and agree to indemnify and hold harmless VSP from any and all liability, including, but not limited to, claims for libel and right to privacy, in connection with this matter.

GENERAL CONSENT FOR CARE AND TREATMENT

By signing below, I certify that I am of legal age and hereby consent to receive a comprehensive or intermediate eye exam, which may include dilation of the eyes, and, if prescribed, lens and frame services through the VSP Vision Eyes of Hope® Mobile Clinics Program. I also hereby authorize and voluntarily consent to VSP's collection, use and disclosure of my patient health information for treatment and health care operational purposes. In addition, I assume responsibilities, liabilities and risks associated with the services I receive from VSP, including communicable diseases and related illnesses such as but not limited to COVID-19.

ACKNOWLEDGEMENT OF MEDIA RELEASE, GENERAL CONSENT FOR CARE AND TREATMENT, NOTICE OF PRIVACY PRACTICES, NONDISCRIMINATION NOTICE & INTERPRETERSERVICES, AND OTHER FORMS

By signing below, I acknowledge that I've been provided and notified of the *Media Release Authorization, General Consent for Care and Treatment, Notice of Privacy Practices (NOPP), Acknowledgement of Receipt of NOPP, Nondiscrimination Notice & Interpreter Services*, *Language Assistance* and *Frequently Asked Questions* forms that are available for me to review and obtain a copy of by visiting **vspeyesofhope.com**, calling **800.877.7195**, or sending an e-mail to **mobileclinic@vsp.com**.

Signature of Patient OR Parent/Guardian _____ **Date** _____

Print Patient Name _____

Patient Phone _____ **Patient Email Address** _____

Print Parent/Guardian Name _____ **Relationship to Patient** _____

☐ **Patient Declines to Authorize Media Release**

Prescription Confirmation Statement

As of June 27, 2024, the FTC issued a ruling that requires prescribers to request the patient sign a confirmation statement that they received their prescription. A copy of the prescription must be provided after the completion of any refractive eye exam, whether or not the patient asks for it and prior to offering to sell or provide the patient glasses or contact lenses.

Digital delivery of said prescription also requires confirmation of receipt and shall also be provided immediately after the eye exam and before offering to sell or provide the patient glasses or contact lenses.

A copy of confirmation of receipt of the prescription shall be stored for three years. The below signature confirms that you were provided a copy of your prescription digitally or by hard copy following the completion of your eye exam.

I, the undersigned, acknowledge that I will be provided a copy of my prescription following the completion of my eyecare exam either digitally or by hard copy.

Signature of Patient OR Parent/Guardian _____

Print Patient Name _____

Patient Phone _____ **Patient Email Address** _____

Print Parent/Guardian Name _____ **Relationship to Patient** _____

Date Signed _____