SPAULDING™
OUTPATIENT CENTER
LEXINGTON

Low Vision Clinic Intake

Date Completed: ______/______/______

Patient Information

Last Name: _____________________________ First Name: _________________________ Middle Initial: ______

Date of Birth: ______/______/______ Sex: Male ☐ Female ☐ Nickname: _____________________

Primary Language: ______________________ Secondary Language: ________________________

Referral Information

Note: Many standardized tests cannot be repeated within one year. Please be sure to bring or send a copy of the most recent therapy, vision, CVI evaluations.

What is it that you would like for us to look at? What would you like to get out of the evaluation(s)?

____

____

____

Has the patient had a functional visual assessment/CVI assessment? Yes ☐ No ☐

If yes, where/when? _____________________________________

Has the patient participated in speech, physical or occupational therapy in the past? Yes ☐ No ☐

If yes, Physical Therapy? ☐ Occupational Therapy? ☐ Speech therapy? ☐

Was the patient discharged from this therapy? Yes ☐ No ☐

Please describe any other services (O&M, TVI):

____

____

Clinical Information

Has the patient had any recent major falls? Yes ☐ No ☐

If yes, please describe.

____

____

Does the patient have any major complaints of pain? Yes ☐ No ☐

If yes, please describe including location.

____

____

What are your current motor concerns?

____

____

Does the patient have difficulty with coordination? Yes ☐ No ☐

If yes, please describe.

____

____

Does the patient have any trouble holding or using small objects or with handwriting? Yes ☐ No ☐

If yes, please describe:

____

____

Indicate the patient's level of independence with activities of daily living.

Task	Unable to do	Some Assistance Needed	Independent
Dressing	☐	☐	☐
Feeding	☐	☐	☐
Toileting	☐	☐	☐
Grooming/Bathing	☐	☐	☐

Does the patient have decreased safety awareness? (i.e. climbing head first out of structures, bolting, taking excessive risks) Yes ☐ No ☐

If yes, please describe:

____

____

Does the patient have an increased activity level or distractibility? Yes ☐ No ☐

If yes, please describe:

____

____

Does the patient seem over or under aroused to certain types of input? Yes ☐ No ☐

If yes, please indicate below "seeks" or "avoids" for all that apply.

Oral	Seeks ☐ Avoids ☐	Gustatory (taste)	Seeks ☐ Avoids ☐
Tactile (touch)	Seeks ☐ Avoids ☐	Proprioceptive (body awareness)	Seeks ☐ Avoids ☐
Auditory	Seeks ☐ Avoids ☐	Vestibular (movement)	Seeks ☐ Avoids ☐
Visual	Seeks ☐ Avoids ☐		

Do you have any current sensory concerns or observations?

____

____

____

Expressive Language

How does the patient communicate?	Example
☐ Gesture (Pointing, pulling, etc)	______________________
☐ Looks toward item	______________________
☐ Uses facial expressions	______________________
☐ Sounds/Word attempts	______________________
☐ Words	______________________
☐ Reaches for objects	______________________
☐ Uses pictures or photos	______________________
☐ Sign Language	______________________
☐ Technology with voice	______________________
☐ Writing/Typing	______________________

Receptive Language

Does the patient point or look at things or pictures when asked? Yes ☐ No ☐

Does the patient follow directions? Yes ☐ No ☐

If yes, ☐ One step directions? ☐ Two step directions? ☐ Multi-step?

Office Use Only

Intake Reviewed By? ______________________ Date: ____________________

Schedule

☐ Multidisciplinary evaluation with ☐ OT ☐ PT ☐ SLP

☐ Single discipline evaluation with ☐ OT ☐ PT ☐ SLP