

**LIONS CLUB VISION / HEARING FORM**

Location: _____

SCREENING NUMBER: _____

Date: _____

WAIVER AND CONSENT: Before participating in this FREE vision/hearing screening, you must read and sign this. This screening is provided by trained Lions Club members and volunteers. Your local Lions Club assumes no risk or responsibility in connection with this screening. By signing this waiver and consent, you acknowledge that you understand that this is a vision and hearing screening and does not take the place of a dilated comprehensive eye examination or hearing exam, and you give your permission for this screening to take place. You also give permission for this information to be used for your further treatment and follow-up. Vision screening, including screening for glaucoma, is recommended by medical experts. Results of this screening will be given to you. In any event, you should consult with your eye doctor to ensure that you fully understand the meaning of the results.

I have read the above Waiver and Consent Form**SIGNATURE:** _____ **DATE:** _____

Name: _____

Address: _____ City, St., Zip: _____

Phone: _____ Date of Birth: _____ Age: _____

Male () Female () Do you have Insurance? (Medicare/Medicaid) Yes No

When was your last eye exam? _____ Do you have diabetes Yes No

Do you wear prescription glasses? Yes () No () Readers? Yes () No ()

RESULTS – NEAR AND FAR VISION:**Visual Acuity:** With glasses _____ Without glasses _____ BP _____ Blood Sugar _____**Far Vision:** Right _____ Left _____ **Near Vision:** Both Eyes _____**Intra Ocular Pressure:** Right _____ Left _____ (Ta,Tpuff,Ts) repeat: _____**Autorefractor:** Right Eye: Sphere: _____ Cylinder: _____ Axis _____ SE _____**SPOT :** Left Eye: Sphere: _____ Cylinder: _____ Axis _____ SE _____**Visual Fields (FDT)- Peripheral Vision:** Pass Refer Unreliable

Right Eye: Total misses: _____ Left Eye: Total misses: _____

Hearing Results: Right Ear: (Circle one) Pass Refer | Left Ear: (Circle one) Pass Refer**Hearing Recommendation:** _____ Schedule an appointment to see a hearing care provider in the near future.**Vision Recommendations:**

() **Glaucoma Consultation:** Schedule an appointment to see an eye care provider in the near future. Your screening results show that you are at risk of developing glaucoma.

() **Ophthalmic Consultation:** Schedule an appointment to see an eye care provider in the near future. Your screening results show that you may have an eye disorder.

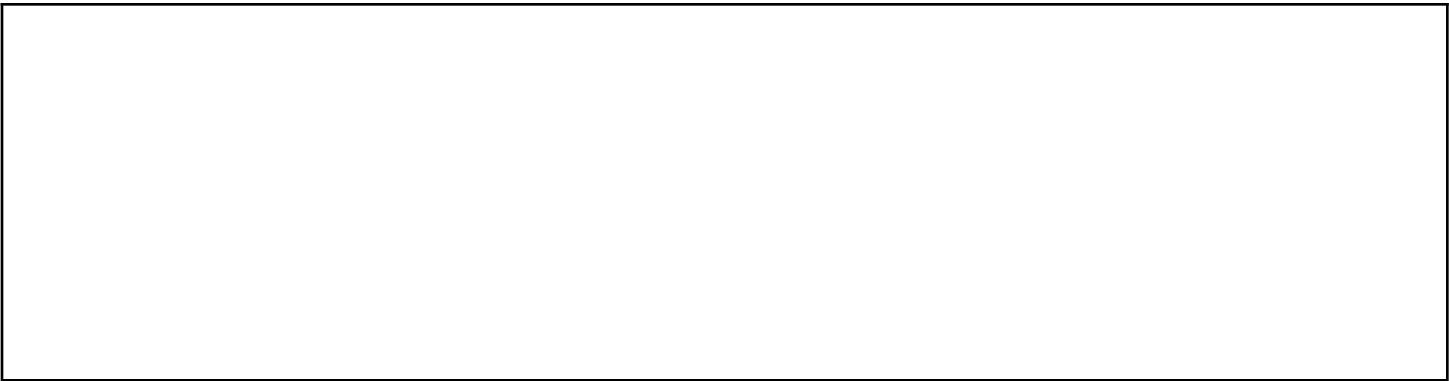
Refer to Florida Lions Eye Clinic (239) 498 3937. Yes/No

() **Routine Follow-up:** Your screening results are within normal limits.

NOTES: __________
Signature: _____

First Sight Glasses Given: OD (Right) _____ (enter power e.g. +1.25) OS (Left) _____

Donated Glasses given _____



5.20.26