# FUNCTIONAL VISION EVALUATION for Adults with Intellectual/Developmental Disabilities

<table>
<thead>
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<th>Name:</th>
<th>DOB:</th>
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<tr>
<td>Evaluator:</td>
<td>Date of Evaluation:</td>
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<td>Location of Evaluation:</td>
<td>Last Eye Exam Date:</td>
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<td>Person Interviewed and Role:</td>
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**Current Medical Information Related to Functional Vision**

**Interview**

- Does individual have glasses prescribed?
- Does individual tolerate wearing glasses?
- Does individual appear to respond to light?
- How much do you feel the individual sees?
- Does the individual seem sensitive to light at times?
- Are there some attributes the person seems to respond more to like colorful items, moving items, bright items?
- Does the individual’s vision seem to be better at some times than others?

**Other:**

**Observations of Functional Vision**

- General Appearance of the Eyes (redness, discoloration, discharge, cataract or white opaque coating, droopy, open/closed, cysts, etc.):

- General Behaviors Noted (rubs, blinks, presses eyes, flaps front of eyes, squints, covers, etc.):

- Nystagmus Present?
- Pupils constrict to light?
- Blink Reflex?
- Eye Preference Noted?
- Eye Alignment – Location of pupil- Right eye: Left eye:
- Light Perception Behaviors:
- Light Sensitivity Behaviors:
- Visual Attending or Fixation:
- Head Posturing?
- Bumps into doorways or objects?
- Knocks things over?
- Oriented to home or other environment?
- Awareness of items or movement to the sides (peripheral):
- Appears to see better to one side or the other?:
- Visual Tracking: Horizontal - Vertical –
### Functional Vision Evaluation for Adults with IDD

#### Name:

**Diagonal –**

**Crosses Midline –**

**Comments:**

| **Gaze Shift:** |  |
| **Visual Scanning:** |  |
| *Where does individual hold an object to look at it?* |  |

**Other Observation Trials related to Functional Vision during Mealtimes or very motivating activity (auditory or other cues eliminated as possible):**

- Awareness:
- Reach toward object:
- Size:
- Contrast:
- Color:
- Lighting:
- Movement:
- Distance:
- Location:
- Other:

**Other Functional Activity Observations:**

**Other Functional Activity Trials:**

**Evaluation Summary:**

- **Visual Strengths:**
- **Visual Challenges:**

**General Recommendations** (include approach, lighting, materials size, color, contrast, shininess, placement, simplification, movement - as applicable)

- •

**General Orientation/Mobility Recommendations**

- •

**Environmental Modifications Recommendations**

- •

**Related Assistive Technology Recommendations**

- •

_________________________  Date:

Evaluator’s Signature

**Distribution:**