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PHYSICIAN'S REPORT ON EYE INJURIES

Refer to Ind. 80.26, Loss of vision; determination

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

PATIENT

WC Claim Number	Employee Name
Social Security Number*	Employee Address

HISTORY

Injury Date	Employer Name	Insurance Company Name

Date of First Treatment	Date of Last Treatment or Exam	Which eye is injured? ☐ Right ☐ Left ☐ Both

If only one eye is injured, is the other eye affected? ☐ Yes ☐ No If Yes, explain:

NATURE OF INJURY AND DIAGNOSIS

Please be as detailed as possible

Is physical condition of the eyes stationary? ☐ Yes ☐ No If No, explain: Have all adequate and reasonable operations been attempted? ☐ Yes ☐ No	1)Did cataract form as a result of injury? ☐ Yes ☐ No 2)If cataract formed, was lens removed? ☐ Yes ☐ No 3)Has there been a surgical implant of lens? ☐ Yes ☐ No	Danger of further impairment? ☐ Yes ☐ No If Yes, explain:

CENTRAL VISUAL READINGS

IMPORTANT: PLEASE FILL OUT EACH LINE COMPLETELY FOR EACH EYE

Distance → Use Snellen test letters or characters up to 20/800.

Near → Use AMA Reading Card up to 14/560.

	After Injury				Pre-existing before injury, including presbyopia and other conditions clearly not the result of the injury.			
	Without Correction		With Correction		Without Correction		With Correction	
	Distance	Near	Distance	Near	Distance	Near	Distance	Near
Right								
Left								

PRIOR DISABILITY

Did the employee wear glasses for pre-existing subnormal vision? ☐ Yes ☐ No
Is there a record or positive indication of pre-existing subnormal vision? ☐ Yes ☐ No If Yes, Explain:

Is the remaining impairment due to the injury? ☐ Yes ☐ No Explain:

BINOCULAR VISION

Is there absence of useful binocular vision? ☐ Yes ☐ No
Explain cause:

If a result of the injury, what is the percentage of additional permanent disability?

Is there any diplopia present? ☐ Yes ☐ No

If Yes, this should be plotted in the chart at the right by placing an X in each square in which diplopia is found. The test is to be made with any industrially useful correction applied.

Was such correction used? ☐ Yes ☐ No

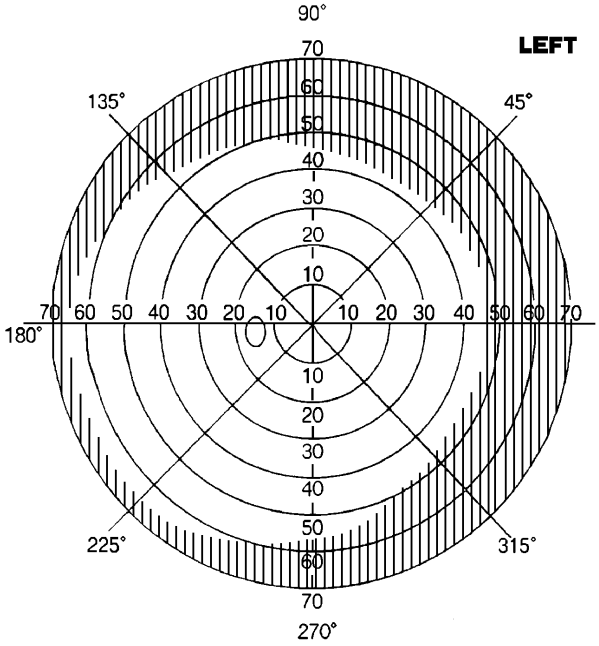
Industrial Motor Field Chart

FIELD VISION

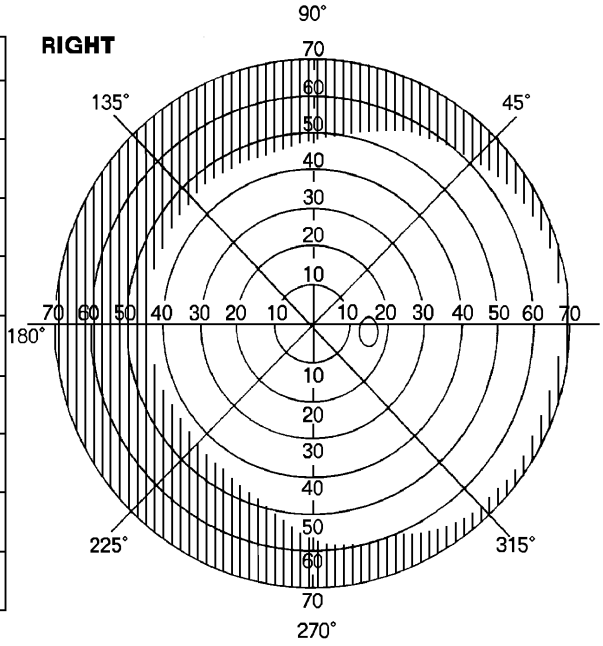
Field vision taken without correction if possible using a white test object which subtends one degree and a standard perimeter with a radius of 12.9 inches (330 mm). The test object shall measure 0.223 inches (5.8 mm).

Is there any loss of the field of vision? ☐ Yes ☐ No Is it the result of the injury? ☐ Yes ☐ No

If so, indicate on the charts and table below. **Sketch impaired area. Sketch areas of any scotomata**.



Left Eye	Meridian	Right Eye
	0	
	45	
	90	
	135	
	180	
	225	
	270	
	315	



When did the last trace of inflammation disappear from the eye?

Date able to return to work:

OTHER FUNCTIONS

Certain ocular disabilities are not covered in the foregoing sections, such as disturbance of accommodation, of color vision, of adaptation to light and dark, metamorphosia, entropion, ectropion, lagophthalmos, epiphora, and muscle disturbances not included under diplopia. Is any such disability present? **If so, explain under "Remarks" below, stating whether it results from the injury, what it is, which eye, or whether both eyes are affected, and your percentage estimate of the impairment of the eye or eyes for industrial use**.

Remarks:

Doctor Signature: _____ Date Signed:

(Required in doctor's own handwriting)

Address: