

Simple Low Vision Assessment for Community Partners

Consumer Information

Name: _____ Birthdate: _____
 Address: _____ County: _____
 Phone: _____ Email: _____
 Gender: Male Female Doesn't Self-Identify Ethnicity: _____

Eye Condition

Cataracts Diabetic Retinopathy Glaucoma Macular Degeneration Other: _____

Other Age-Related Impairments

Cognitive or Intellectual Impairment	Mental Health Impairment	Stroke or Brain Injury
Communication Impairment	Mobility Impairment	No Age-Related Impairment
Hearing Impairment	Cardiovascular Disease	Other (Please explain): _____

Items Dispensed

20/20 Pen (#51)	Check Writing Guide (#211)	TED Brochure
Infila Needle Threader (#72)	Word Search – Large-Print (#85)	NoIR 701 Outdoor Sunglasses (#90) Medium Amber
Bump Dots-Orange (#163)	Keychain Talking Clock (#56)	NoIR 702 Outdoor Sunglasses (#88) Medium Grey Green
Vision Aids Sources List	Communication Center Sign-up Form	NoIR 711 Indoor Sunglasses (#91) Light Amber
Bold-Line Paper – 3/4" (#49)	Signature Guide-Small (#41)	NoIR U88 Indoor Sunglasses (#94) Light Plum
Calendar – Large-Print (#80)	Playing Cards – Large- Print (#86)	
Kitchen Timer – Large Print (#69)	3X Illuminated Pocket Magnifier (#242)	
Amsler Grid		

Additional Information

Current vision loss may warrant further intervention	Currently working with SSB Counselor
The senior wishes to be contacted by SSB	The senior does not wish to see SSB

Notes: _____ Send Equipment to: _____



Consent Form

I understand that the information I am providing on this form is for recording and reporting purposes.

The information will be used by MN State Services for the Blind and _____ to create statistical reports that will not identify me as an individual. I understand that I am not required to sign this form. By not signing this form, I understand that the community partner visiting me today is unable to leave any low vision aids and devices with me. This information will not be released to anyone other than the above-mentioned parties in any way that will identify me as an individual unless SSB is required to do so by court order or legislative auditor. For any other purpose, I will be asked to sign a separate consent form.

Signature: _____ Today's Date: _____

Printed Name of Customer: _____

Verbal Consent Obtained by: _____ Date: _____

Community Partner Information (replacement items will be sent here)

Name of Organization: _____

Name of Community Partner: _____

Manager or Supervisor's Name: _____

Address: _____

Email: _____ Phone Number: _____

You can fax or email the form to 651-649-5927 or stacy.shablott@state.mn.us