REPUBLIC OF KENYA

MINISTRY OF HEALTH

Ref: MOH/276B

ASSESSMENT FORM FOR VISUAL IMPAIRMENTS

Name of Health Facility:		Date:	DD	MM	YYYY

Applicant Information for the purpose of reporting on Disability Assessment:

Name:		ID No.		Gender:	
Date of Birth: Age:	DD / MM / YYYY	Occupation:		Phone No.	
County:		Sub-County:		Marital Status:	

Next of Kin Details:

Name:		Relation:		Phone No.	

Assembled Medical Team details:

MEMBERS	NAME	REG. NO.	SIGNATURE	Health Facility Official Stamp
Chairperson				
Member				
Member				
Member				

(***I understand that giving false information is punishable by the laws of Kenya)***

Note: the committee should have a minimum of three Members

HISTORY

ASSISTIVE DEVICE

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MEDICAL HISTORY

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OCULAR HISTORY

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Distance Visual Acuity	With Correction		Without Correction
Right Eye			
Left Eye			
Near Vision Test			

Ophthalmic Examination

Examination	Right Eye	Left Eye		Right Eye	Left Eye
Present eyeball			Cornea		
Squint			Anterior Chamber		
Nystagmus			Iris		
Tearing			Pupil		
Lids			Lens		
Conjunctiva			Fundus		

Specialized Tests

Test	Findings/Defect
Humphreys Visual Field	
Colour Vision	
Stereopsis	

Conclusion

Category	*Tick*	Cause of Vision Impairment		
Normal				
Mild Impairment		**Percentage Disability**		
Moderate Impairment				
Severe Impairment		**Any Possible Intervention**	Yes	
Blind			No	
Near Vision Impairment		**Recommendation**		

TEMPORARY ☐ PERMANENT ☐

VERIFIED BY THE COUNTY DIRECTOR OF HEALTH

Name.....

Date .....

Signature.....

COUNTY DIRECTOR OF HEALTH OFFICIAL STAMP