Australian Government
Department of Veterans' Affairs

Eye Condition(s)
Medical Impairment Assessment

Veteran	UIN

Please assess the following conditions:

1. Please record the veteran's **corrected visual acuity**.

Right Eye	Left Eye

2. Please select the most accurate description of any **visual field defects**.

Description	Right Eye	Left Eye
Normal fields.	☐	☐
Hemianopia (indicate if homonymous, binasal or bitemporal).	.....	
Other visual field loss (please provide % loss).	%	%

3. Please describe any **abnormality of eye position or movement**. Consider nerve palsies, nystagmus, heterotropia, gaze defects, squints, etc. Please be as specific as possible.

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4. Please select **all** that apply in relation to any **lens disorders**.

Description	Select
None.	☐
Cataract (in one or both eyes).	☐
Intraocular lens (in one or both eyes).	☐
Unilateral aphakia.	☐
Bilateral aphakia.	☐

5. Please select **all** that apply in relation to **anatomical changes of the eyelids**.

Description	Select
Uncorrected **ectropion** or **entropion.**	☐
Ptosis or **tarsorrhaphy resulting in partial closure** of the eye.	☐

6. Please select the most accurate description of any **conjunctivitis**.

Description	Select One
None.	☐
Occasional: **less than 6** separate episodes **per year**.	☐
Intermittent: **at least 6** separate episodes **per year**.	☐
Chronic, with constant irritation.	☐
Severe eye irritation, **present at all times**.	☐

7. Please select the most accurate description of any other conditions causing **eye irritation**.

Description	Select One
None.	☐
Constant but **mild**.	☐
Severe eye irritation, **present at all times**.	☐

8. Does the veteran use lubricating eye drops on a daily basis? ☐ Yes ☐ No

9. Are there any other comments you would like to make regarding the impact of the veteran's visual or ocular condition(s)?

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10. Please list **all conditions** contributing to the reported impairment and indicate the **percentage contribution**. Include any previously known condition(s) and any new condition(s) you have identified. The contribution total must equal 100%.

Condition	Contribution %
e.g. Macular degeneration	75%
Total	**100%**

Doctor/Optometrist's signature	Doctor/Optometrist's name	Date	Time to complete form

Save Print Clear