DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

PHYSICIAN'S REPORT ON EYE INJURIES

P.O. Box 58
Jefferson City, MO 65102-0058
573-751-4231
labor.mo.gov/DWC

NOTE: This report is required in each case of eye injury resulting in any degree of permanent disability so that a correct evaluation of the loss sustained may be made and the amount of compensation due for it accurately computed.

IN ORDER FOR THIS FORM TO SERVE ITS PURPOSE, ALL REQUESTED DATA MUST BE PROVIDED.

State's Number For:	File: _____ Carrier: _____ Employer: _____
Carrier's File No. _____	

Eye injuries not resulting in any permanent disability should be reported on the regular report form, Medical Treatment Form (WC-9).

The Patient

1. Name of Injured Person _____ Age _____ Sex _____
2. Address _____

   City _____ State _____
3. Name and Address of Employer _____

The Accident

4. Date of Accident _____ Hour _____ ☐ a.m. ☐ p.m. Date disability began _____
5. State (in patient's own words) where and how accident occurred _____

The Injury

6. Which eye was injured? _____ 7. Is other eye affected by injury? ☐ Yes ☐ No
8. Nature of injury and diagnosis _____
9. Is condition of eye(s) not stationary? ☐ Yes ☐ No
10. Have all adequate and reasonable operations and treatment been attempted? ☐ Yes ☐ No

    If No, explain: _____

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

I. CENTRAL VISUAL ACUITY READINGS

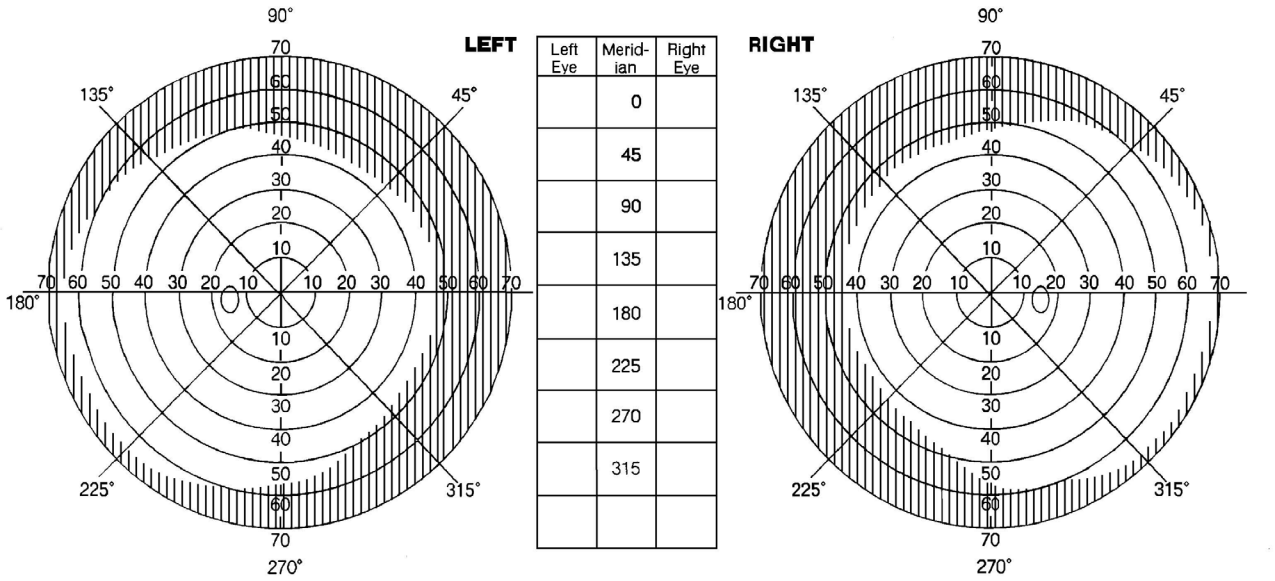
	Without Any Corrective Lenses		With Correction Only for Natural Presbyopia and Other Conditions Clearly Not the Result of Injury	
	Distance	Near	Distance	Near
11. Right Eye				
12. Left Eye				

II. FIELD OF VISION

NOTE: The field of vision shall be determined on a standard perimeter using white test target of 1 degree.

13. Is there any loss of field of vision? ☐ Yes ☐ No

14. Is it a result of injury? ☐ Yes ☐ No If "Yes," show below by tracing the reduced field in outline on the applicable figure and by giving reading found at the eight principal meridians in the center box.



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

III. BINOCULAR VISION

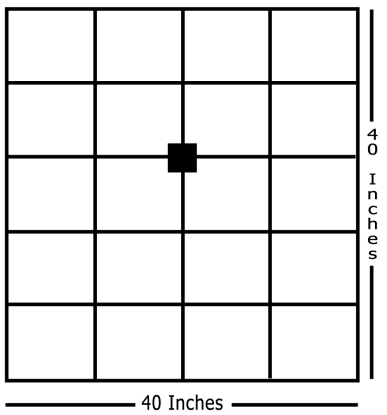
NOTE: Test is to be made without corrective lenses or prisms.

15. Is there useful binocular vision? ☐ Yes ☐ No

16. Is there any diplopia (double vision) present? ☐ Yes ☐ No

17. If Yes, plot on the accompanying chart by placing an X in each rectangle where diplopia is present.

Motor Field Chart



Motor field chart at 40 inches is approximately 40 inches square, and the 20 rectangles measure 8 inches by 10 inches.

IV. SECONDARY OCULAR DISABILITIES

18. If there are ocular disabilities other than those covered in the foregoing sections, please indicate them below by appropriate checking, and if any of the first three are checked indicate under "Remarks" your estimate of the percentage.

If any secondary disability exists that is not listed, note it in the blank space provided.

If there are no secondary disabilities, check this box ► ☐

A. Paralysis of Accommodation ..... ☐

B. Ectropion ..... ☐ or Entropion ..... ☐

Unilateral ..... ☐

Bilateral ..... ☐

C. Iridectomy (Traumatic or Surgical)

Photophobia and Dazzling ..... ☐

D. Lagophthalmos ..... ☐

Unilateral ..... ☐

Bilateral ..... ☐

E. Epiphora

Unilateral ..... ☐

Bilateral ..... ☐

F. Symblepharon (Also Limited Muscle Function) .. ☐

G. Ptosis

Unilaterial ..... ☐

Bilateral ..... ☐

H. Eye Brow (Complete Loss of)

Unilateral ..... ☐

Bilateral ..... ☐

I. Eye Lashes (Complete Loss of)

Unilateral ..... ☐

Bilateral ..... ☐

J. Cataract (Traumatic) ..... ☐

K. Dislocation of Lens (Traumatic)

Partial ..... ☐

Complete ..... ☐

L. Scotoma (Traumatic) ..... ☐

If NOT centrally located ..... ☐

M. _____

_____

_____

_____ ☐

19. REMARKS _____

_____

_____

_____

_____

_____

_____

(over)

V. PRE-EXISTING SUBNORMAL VISION

20. Is there record of adequate and positive indication of pre-existing subnormal vision? ☐ Yes ☐ No

If Yes, explain: _____

21. Is there likelihood of further impairment of the pre-existing subnormal vision, as a result of this injury? ☐ Yes ☐ No

If Yes, explain: _____

VI. CONDITIONS REQUIRING DELAYED FINAL EXAMINATION

In cases of disturbance of extrinsic ocular muscles, optic nerve atrophy, retained intraocular foreign body, injury to the retina, sympathetic ophthalmia, and traumatic cataract, at least six months – preferably not more than from 12-16 months – must elapse before final examination shall be made on which this report is based.

22. If any of the conditions mentioned immediately above exist, is there likelihood of further impairment occurring as a result of the injury? ☐ Yes ☐ No

If Yes, explain: _____

23. Date of Examination _____ Date of Report _____

24. Doctor's Signature *(Required in doctor's own handwriting)* _____

25. Address _____

City _____ State _____