

OPHTHALMOLOGY EXAMINATION REPORT

COMPLETE THIS PAGE FULLY AND IN BLOCK CAPITALS - REFER TO INSTRUCTIONS PAGES FOR DETAILS

Austria

Medical in Confidence

(1) JAA State of licence issue:	(2) Class of medical certificate applied for: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 (ATC) <input type="checkbox"/> Others	
(3) Surname:	(4) Previous surname(s):	(12) Application: <input type="checkbox"/> Initial <input type="checkbox"/> Renewal/Revalidation
(5) Forenames:	(6) Date of birth:	(7) Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
(8) Place and country of birth:	(9) Nationality:	(13) System reference number:
(14) Type of licence applied for:		
(301) Consent to release of medical information: I hereby authorise the release of all information contained in this report and any or all attachments to the Aeromedical Examiner, the Authority and where necessary the Aeromedical Section of another State, recognising that these documents or any other electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the Authority, providing that I or my physician may have access to them according to the national law. Medical Confidentiality will be respected at all times.		
Date:	Signature of the applicant:	Signature of the medical examiner (witness):

(302) Examination Category: <input type="checkbox"/> Initial <input type="checkbox"/> Extended <input type="checkbox"/> Renewal/Reval <input type="checkbox"/> Special referral	(303) Ophthalmological history:
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Clinical examination:		Normal	Abnormal
Check each item			
(304) Eyes, external & eyelids		<input type="checkbox"/>	<input type="checkbox"/>
(305) Eyes, Exterior (slit lamp, ophth.)		<input type="checkbox"/>	<input type="checkbox"/>
(306) Eye position and movements		<input type="checkbox"/>	<input type="checkbox"/>
(307) Visual fields (confrontation)		<input type="checkbox"/>	<input type="checkbox"/>
(308) Pupillary reflexes		<input type="checkbox"/>	<input type="checkbox"/>
(309) Fundi (Ophthalmoscopy)		<input type="checkbox"/>	<input type="checkbox"/>
(310) Convergence	cm	<input type="checkbox"/>	<input type="checkbox"/>
(311) Accommodation	D	<input type="checkbox"/>	<input type="checkbox"/>

(312) Ocular muscle balance (in prisme dioptres)	
Distant at 5/6 meters	Near at 30-50 cm
Ortho	Ortho
Eso	Eso
Exo	Exo
Hyper	Hyper
Cyclo	Cyclo
Tropia <input type="checkbox"/> Yes <input type="checkbox"/> No	Phoria <input type="checkbox"/> Yes <input type="checkbox"/> No
Fusional reserve testing <input type="checkbox"/> Not performed <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

(313) Colour perception	
Pseudo-Isochromatic plates	Type:
No of plates:	No of errors:
Advanced colour perception testing indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No
Method:	
<input type="checkbox"/> Colour SAFE	<input type="checkbox"/> Colour UNSAFE

(314) Distant vision (at 5m/6m)		Spectacles	Contact lenses
Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		

(315) Intermediate vision (at 1 m)		Spectacles	Contact lenses
Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		

(316) Near vision (at 30-50 cm)		Spectacles	Contact lenses
Right eye	Corrected to		
Left eye	Corrected to		
Both eyes	Corrected to		

(317) Refraction		Sph	Cylinder	Axis	Near (add)
Right eye					
Left eye					
<input type="checkbox"/> Actual refraction examined		<input type="checkbox"/> Spectacles prescription based			

(318) Spectacles	(319) Contact lenses
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type:	Type:

(320) Intra-ocular pressure			
Right	mmHg	Left	mmHg
Method:			
<input type="checkbox"/> Normal		<input type="checkbox"/> Abnormal	

(321) Ophthalmological remarks and recommendation:

(322) Examiner's declaration:		
I hereby certify that I/my AME group have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.		
(323) Place and date:	Examiner's Name and Address: (Block Capitals)	AME or Specialist No:
Authorised Medical Examiner's Signature:	Telephone No.:	
	Telefax No.:	