SPECIAL EYE REPORT

1. Name		2. CAA Client No.	
3. Postal Address		4. Date of Birth	

5. Certificate(s) applied for

Class 1 ☐ Class 2 ☐ Class 3 ☐

6. Applicant's Signature: (To be signed in front of examiner).

Date / /

7. HISTORY/FAMILY HISTORY of relevant diseases (e.g. diabetes), vision problem (e.g. glaucoma), or surgery (e.g. refractive).

8. VISUAL ACUITY

	Distance (6 m) Class 1 and 3: each 6/9, Binocular 6/6 Class 2: each 6/12, Binocular 6/9			**Intermediate** (100 cm) Class 1 and 3: std N14			**Near** (30-50 cm) Class 1, 2 and 3 std N5		
	Right	Left	Both	Right	Left	Both	Right	Left	Both
Uncorrected	6/			N			N		
with Main Correction	6/			N			N		
Standby Correction	6/			N			N		

9. PRESCRIPTION

	Distance			**Intermediate**			**Near**		
		Right	Left		Right	Left		Right	Left
Main Correction Please specify type of correction used	Main	DS / DC / Ax		Main	DS / DC / Ax		Main	DS / DC / Ax	
Standby Correction Please specify type of correction used	Standby	DS / DC / Ax		Standby	DS / DC / Ax		Standby	DS / DC / Ax	

10. CONTACT LENSES (if used)

a. Type?

b. How long in use?

c. Detail any contact lens associated pathology

d. Well tolerated? (e.g. long haul flying) Yes ☐ No ☐

e. Fit and Power adequate? Yes ☐ No ☐

11. COLOUR PERCEPTION – Standard ISHIHARA 24-plate book.

a. Are the first 17 plates read with ONE error or less? Yes ☐ No ☐
Record errors as an, '**X**' in the appropriate box.

b. If **NO** please provide a full report.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17

12. MUSCLE BALANCE

		Normal	**If abnormal please specify dioptres and provide fusional reserves.**
a. Cover Test		☐	
b. Distance	Exo <12 △	☐	
	Eso <6 △	☐	
	Hyper <1 △	☐	
c. Near	Exo <12 △	☐	
	Eso <6 △	☐	
	Hyper <1 △	☐	

13. OTHER TESTS

	Normal	**If abnormal please specify**
a. Binocular single vision	☐	
b. Fundi, media and corneas	☐	
c. Visual fields by confrontation	☐	
d. Intraocular pressure/optic nerve	☐	
e. Contrast sensitivity/glare/ haze **must** be checked with all refractive surgery. (Loss of VA in glare abnormal if more than 2 lines).	☐	

14. ADDITIONAL REMARKS (Comments or further action recommended?)

15. Print Examiner's Name and Address
(Practice Stamp Preferred)

Telephone Number

Facsimile Number

16. Client's ID: Indicate the type of photographic ID sighted, serial number and expiry date.

17. Examiner's Declaration: I hereby certify that I personally identified and examined the applicant named on this medical report and that this report, with any attached notes, embodies my examination completely and correctly.

Examiner signature Date / /

SPECIAL EYE REPORT – GUIDANCE FOR APPLICANTS & EXAMINERS

IMPORTANT: Please refer to the General Directions (GD's) for instructions regarding the timing and nature of the tests. (www.caa.govt.nz) The comments below are intended to provide practical advice to ensure that the report is completed satisfactorily and provides the information necessary for an aeromedical assessment.

Purpose of Form:

- **Must** be used for **Special Vision Examination** (as detailed in GD/Gen/02/04 Part 8 & 9.) and completed by registered Ophthalmologist or a CAA credentialled optometrist (see www.nzao.co.nz/locate-an-optometrist-for-caa, "Links/CAA Eyesight Examiners").
- **Should** be used for examination **following replacement of glasses**. Use Sections 8 – 10 as template for all optometrists, credentialled optometrists and ophthalmologists (other sections only as clinically indicated).

Applicant Notes:

- The Applicant should fill in Sections 1 – 5.
- The Applicant should sign the form **in front of the Examiner**.
- The following **MUST** be taken to the examination
  - **Photographic ID** as specified in the GD. (For example Passport, Firearm Licence, Driving Licence.)
  - **Glasses and/or contact lenses**, and any stand-by correction which are or may be used when flying.
- Applicants should be aware that the examination may require dilatation of the pupil with eyedrops. This causes blurring of vision and renders the applicant unable to drive (or fly) for several hours afterwards. It is important to check with the examiner how long the effect might last.

Examiner Notes:

- Please **check ID** and witness the **signature** (or get Applicant to re-sign if already signed).
- Advise Applicant of effects of **pupillary dilatation** (if applicable).
- Testing should show the results with correction **actually used**. Likewise, Section 9, the "Prescription" should record refraction actually in use.
- Specify type of **main** and **standby correction** used (ie lookover, bifocal, varifocal etc) on the form.
- Even if a different prescription might improve vision, the Report must state results for correction that is used. Any **change of prescription requires retesting**.
- Applicants with distance Visual Acuity of **less than 6/24** uncorrected **must** carry standby glasses. These too must be tested.
- Please ensure "Normal" findings are recorded with a tick. If there are significant findings on examination (eg on fundoscopy), please **use a continuation sheet** if needed.
- Please ensure that the examiner's name and contact details are **legible** too!

Thank you.