

STEREO OPTICAL REHAB G RECORD FORM FOR THE OPTEC® VISION TESTER

NAME _____

DATE _____

ADDRESS _____

AGE _____

CITY _____ STATE _____ ZIP _____

WEARING GLASSES Y ☐ N ☐

ADMINISTRATOR _____

CONTACT LENSES Y ☐ N ☐

CATARACT FUNCTIONAL DISABILITY TEST



Mark Pass: **P** or Fail: **F** for each lighting condition below

P / F ☐	P / F ☐	P / F ☐	P / F ☐
NIGHT WITHOUT GLARE Target = 3cd/m ²	NIGHT WITH GLARE Target = 3cd/m ² Glare = 28 Lux	DAY WITHOUT GLARE Target = 85cd/m ²	DAY WITH GLARE Target = 85cd/m ² Glare = 138 Lux
9 ☐ ☐	9 ☐ ☐	9 ☐ ☐	9 ☐ ☐
8 ☐ ☐	8 ☐ ☐	8 ☐ ☐	8 ☐ ☐
7 ☐ ☐	7 ☐ ☐	7 ☐ ☐	7 ☐ ☐
6 ☐ ☐	6 ☐ ☐	6 ☐ ☐	6 ☐ ☐
5 ☐ ☐	5 ☐ ☐	5 ☐ ☐	5 ☐ ☐
4 ☐ ☐	4 ☐ ☐	4 ☐ ☐	4 ☐ ☐
3 ☐ ☐	3 ☐ ☐	3 ☐ ☐	3 ☐ ☐
2 ☐ ☐	2 ☐ ☐	2 ☐ ☐	2 ☐ ☐
1 ☐ ☐	1 ☐ ☐	1 ☐ ☐	1 ☐ ☐
C	C	C	C

If the subject falls only in the gray-shaded area, then a full contrast sensitivity test, with five test slides, should be given.

CATARACT FUNCTIONAL DISABILITY TEST



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P / F ☐	P / F ☐	P / F ☐	P / F ☐
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9 ☐ ☐	9 ☐ ☐	9 ☐ ☐	9 ☐ ☐
8 ☐ ☐	8 ☐ ☐	8 ☐ ☐	8 ☐ ☐
7 ☐ ☐	7 ☐ ☐	7 ☐ ☐	7 ☐ ☐
6 ☐ ☐	6 ☐ ☐	6 ☐ ☐	6 ☐ ☐
5 ☐ ☐	5 ☐ ☐	5 ☐ ☐	5 ☐ ☐
4 ☐ ☐	4 ☐ ☐	4 ☐ ☐	4 ☐ ☐
3 ☐ ☐	3 ☐ ☐	3 ☐ ☐	3 ☐ ☐
2 ☐ ☐	2 ☐ ☐	2 ☐ ☐	2 ☐ ☐
1 ☐ ☐	1 ☐ ☐	1 ☐ ☐	1 ☐ ☐
C	C	C	C

If the subject falls only in the gray-shaded area, then a full contrast sensitivity test, with five test slides, should be given.



**STEREO
OPTICAL**

STEREO OPTICAL CO., INC.

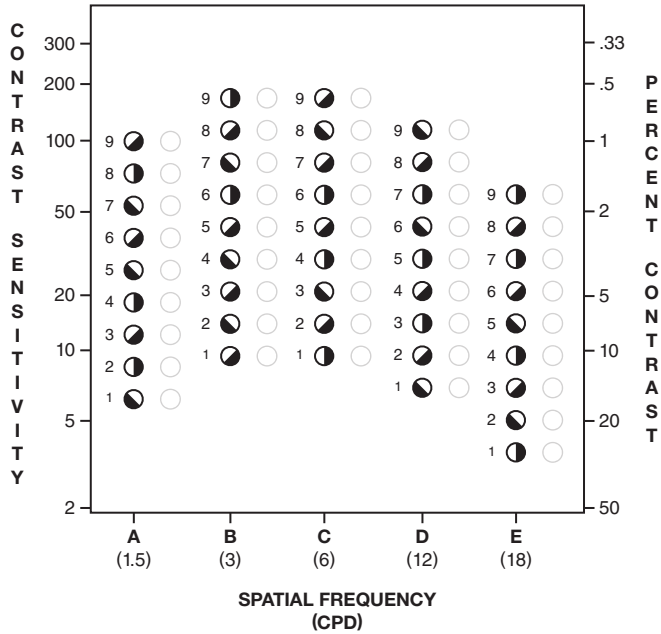
8600 W. Catalpa Avenue, Ste. 703

Chicago, IL 60656 USA

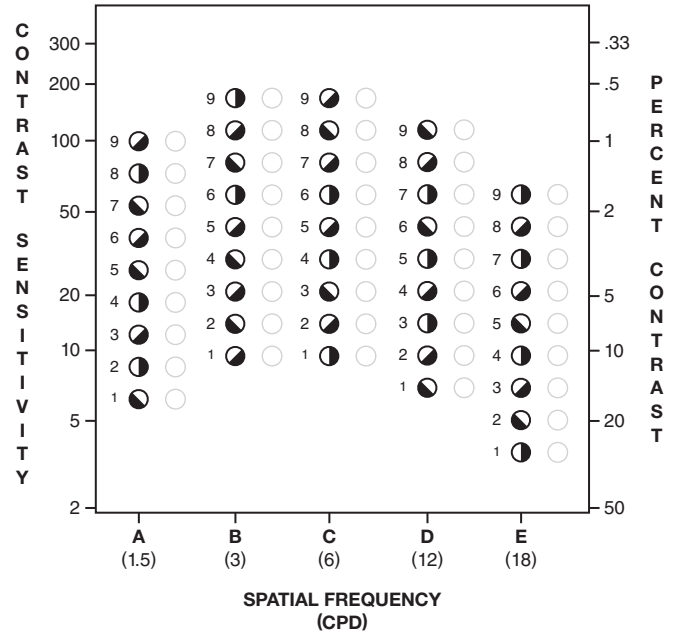
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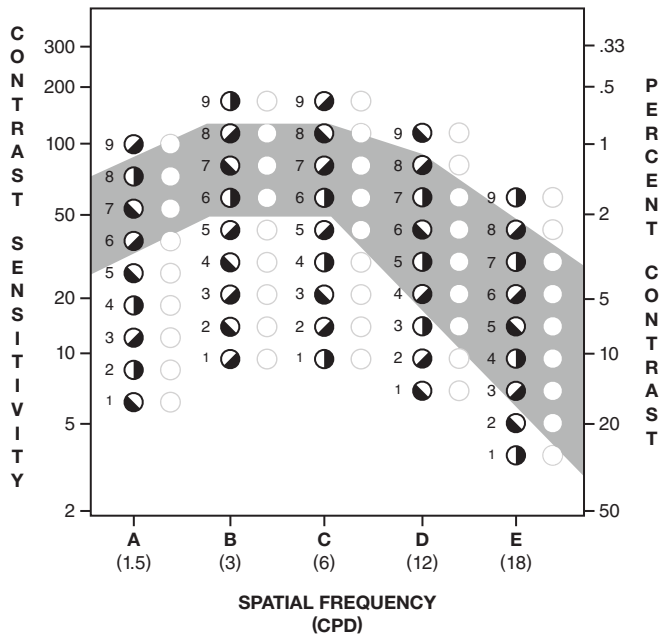
NIGHT TESTING WITHOUT GLARE



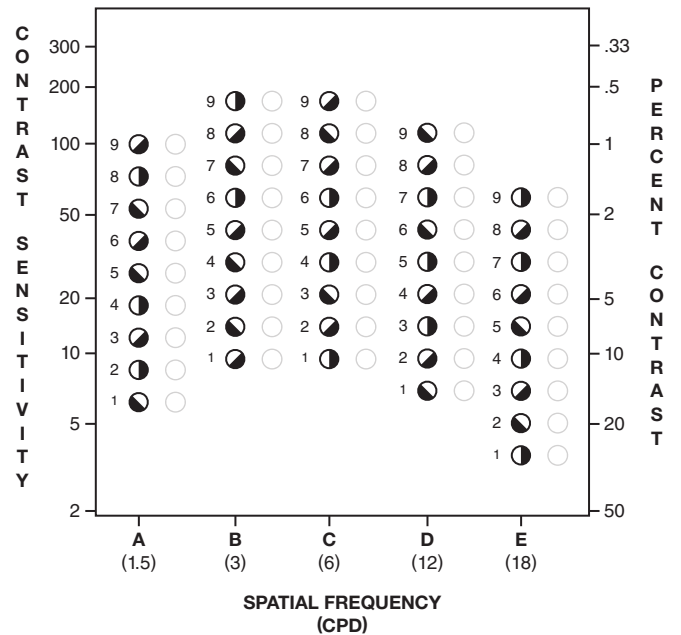
NIGHT TESTING WITH GLARE



DAY TESTING WITHOUT GLARE



DAY TESTING WITH GLARE



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