

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**REPORT OF LEGAL BLINDNESS / REQUEST FOR INFORMATION**  
NYS COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED

*Please complete this information in full in order to avoid delay in registration of the patient and/or receipt of information requested.*

**REPORT OF LEGAL BLINDNESS: (Complete this part to report legal blindness)**

**PATIENT INFORMATION**

NAME (Last):	(First):	MI	Sex	Birth Date:	Social Security Number:
STREET ADDRESS:				TELEPHONE NO: ( ) -	
CITY:	STATE: <b>NY</b>	ZIP CODE:		COUNTY OR NYC BOROUGH:	

**EXAMINER**

**PLEASE CHECK THE APPROPRIATE CONDITION AND CAUSE: (Optometrist not required to indicate cause)**

CONDITION	CAUSE
1. <input type="checkbox"/> Blindness, both eyes, no light perception	1. <input type="checkbox"/> Cataracts
2. <input type="checkbox"/> Blindness, better eye, with best correction not more than 20/200	2. <input type="checkbox"/> Glaucoma
3. <input type="checkbox"/> Blindness, better eye, with visual field limitation less than 20 degrees	3. <input type="checkbox"/> All other diseases:
4. <input type="checkbox"/> Patient was registered as blind, is now <b>not blind</b> . <i>(Please check cause # 7)</i>	4. <input type="checkbox"/> Congenital condition
	5. <input type="checkbox"/> Accident, poisoning, exposure, or injury
5. <input type="checkbox"/> This person is employed and is expected to become legally blind within the year.	6. <input type="checkbox"/> Unspecified cause
	7. <input type="checkbox"/> Improved Vision

**PART A**

EXAMINER NAME:	PROFESSION OF EXAMINER: <input type="checkbox"/> Physician <input type="checkbox"/> Optometrist	EXAM DATE:
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
TELEPHONE NO.: ( ) -		
EXAMINER SIGNATURE: <b>X</b>		

**FOR INDIVIDUALS UNDER 18, THE NAME AND ADDRESS OF THE PARENT/GUARDIAN IS REQUIRED:**

PARENT/GUARDIAN:	LAST NAME:	FIRST NAME:
STREET ADDRESS:		
TELEPHONE NO.	( ) -	CITY:
		STATE
ZIP CODE:		

**SUBMITTER (IF DIFFERENT FROM ABOVE)**

SUBMITTER'S NAME:	LAST NAME:	FIRST NAME:
STREET ADDRESS:		
TELEPHONE NO.:	( ) -	CITY:
		STATE
ZIP CODE:		

**REQUEST FOR INFORMATION: (Complete this section if the individual is seeking information from CBVH)**

**PART B**

- How I can perform household tasks
- How CBVH can assist me in preparing for a job
- How CBVH can assist me in keeping my current job
- How CBVH can assist in providing services to the above named visually impaired child
- Other services (specify):

Contact Person:	Phone No. ( ) -
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**REPORT OF LEGAL BLINDNESS (Part A)**  
**(To be completed by Ophthalmologist, Optometrist or other Physician)**

The Eye Report section of this form is to be completed for all persons who meet the following criteria for legal blindness:

- Central Visual Acuity of 20/200 or less in the better eye with the use of a corrective lens OR
- A limitation in the visual field, in the better eye, less than 20 degrees.

**REQUEST FOR INFORMATION (Part B)**  
**(To be completed by or for a legally blind individual)**

In addition to reporting to CBVH that this person is legally blind, we would like you to ask your patient if he/she is experiencing any difficulties performing tasks or activities. If so, please assist or have the patient complete the bottom portion on the front side of this form and advise him or her that it will be forwarded to CBVH. Then, please forward the form to the CBVH office listed below that serves the County/Borough in which this individual resides. Your patient will be contacted about rehabilitation services.

<u>Counties Served</u>	<u>Send To:</u>	<u>Counties Served</u>	<u>Send To:</u>		
Allegany	<p align="center"><b>CBVH</b>  <b>Ellicott Square Building</b>  <b>295 Main Street</b>  <b>Room 590</b>  <b>Buffalo, New York 14203</b></p>	Broome	<p align="center"><b>CBVH</b>  <b>The Atrium, Suite 105</b>  <b>2 Clinton Square</b>  <b>Syracuse, New York 13202</b></p>		
Cattaraugus		Cayuga			
Chautauqua		Chemung			
Erie		Chenango			
Genesee		Cortland			
Livingston		Herkimer			
Monroe		Jefferson			
Niagara		Lewis			
Ontario		Madison			
Orleans		Oneida			
Steuben		Onondaga			
Wayne		Oswego			
Wyoming		Schuyler			
Yates		Seneca			
				St Lawrence (Children)	
Albany	<p align="center"><b>CBVH</b>  <b>155 Washington Avenue</b>  <b>2nd Floor</b>  <b>Albany, New York 12210</b></p>	Tioga	<p align="center"><b>CBVH</b>  <b>445 Hamilton Avenue</b>  <b>Room 503</b>  <b>White Plains, New York 10601</b></p>		
Clinton		Tompkins			
Columbia					
Delaware		Dutchess			
Essex		Orange			
Franklin		Putnam			
Fulton		Rockland			
Greene		Sullivan			
Hamilton		Ulster			
Montgomery		Westchester			
Otsego					
Rensselaer					
Saratoga					
Schenectady		Nassau			
Schoharie		Suffolk			
St. Lawrence (Adults)		Queens			
Warren					
Washington					
				<b><u>Boroughs Served:</u></b>	<p align="center"><b>CBVH</b>  <b>20 Exchange Place</b>  <b>2<sup>nd</sup> Floor</b>  <b>New York, NY 10005</b></p>
		Brooklyn			
		Bronx			
		Manhattan			
		Staten Island			