Answer sheet

Patient name: _____

NHS no: _____

1 Ask the patient some questions	Actions
When did you last have a sight test? (Should be every year)	Date of last sight test:
Do you wear glasses?	Yes No
Are your glasses up to date?	Yes No Date of last pair:
What do you wear your glasses for?	Circle one: reading/distance/everything [bifocals/varifocals]
Have you got your glasses with you?	Yes No
Do you have any eye conditions? If so, are you using any prescribed treatment? (eg eyedrops for glaucoma)	Eye condition: Prescribed treatment names:

2 Check distance vision	Actions
Can you see the television clearly at home?	Yes No
Can you read this? *or* Tell me what the picture is?	Yes No

3 Check near vision	Actions
Can you usually see to read newspaper print, shopping lists or medicine labels?	Yes No
Can you read this *or* tell me what the picture is?	Yes No

Date and time: _____

Signature: _____

Print name: _____

Designation: _____

Answer sheet

Patient name: _____

NHS no: _____

4 Check side vision	Actions

There is no need for the patient to wear their glasses. The object of this check is to **compare the patient's peripheral/side vision with yours**. The patient's vision should be roughly the same as yours.

Can see your hand at the **2 o'clock position?**



Yes No

Can see your hand at the **4 o'clock position?**



Yes No

Can see your hand at the **8 o'clock position?**



Yes No

Can see your hand at the **10 o'clock position?**



Yes No

Date and time: _____

Signature: _____

Print name: _____

Designation: _____

Answer sheet

Patient name: _____

NHS no: _____

5 Check eye movements	Actions
There is no need for the patient to wear their glasses. The object of this check is to **see if the patient has double vision or difficulty looking to the side**.	
Do you ever get double vision/see two of things?	Yes No
Do the patient's eyes look straight?	Yes No
Do the patient's eyes jiggle about/not keep still?	Yes No
Do the patient's eyes move together to follow pen?	Yes No
Does the patient complain of double vision during the test?	Yes No

Next steps

> **Document your concerns and immediate actions in the falls care plan.**

> **Inform the medical team.**

Date and time: _____

Signature: _____

Print name: _____

Designation: _____