

Simple Low Vision Assessment – Consumer Information Name: Phone: Address: Birthdate: ☐ Female **Gender:** □ Male Doesn't Self-Identify County: Zip **Ethnicity:** City: **Eye Condition:** Glaucoma Macular Degeneration Cataracts Diabetic Retinopathy Other **Items Dispensed** Signature Guide-Small 20/20 Pen (#51) Bold-Line Paper - ¾" Check Writing Guide NoIR 701 Outdoor Sunglasses (#90) (#49) Medium Amber (#211)(#41)Crossword Puzzle Book -Playing Cards - Large-NoIR 702 Outdoor Sunglasses (#88) Infila Needle Threader Calendar - Large-Print Print (#86) Medium Grey Green (#72)(#80)Large-Print (#84) Bump Dots-Orange Kitchen Timer - Large **Keychain Talking Clock** 3X Illuminated Pocket NoIR 711 Indoor Sunglasses (#91) Print (#69) Magnifier (#242) Light Amber (#163)(#56)Communication Center NoIR U88 Indoor Sunglasses (#94) Vision Aids Sources **Amsler Grid TED Brochure** Light Plum List Sign-up Form Other Age Related Impairments Cognitive or Intellectual Communication **Hearing Impairment** Mental Health **Mobility Impairment** Impairment Impairment Impairment Other, Please explain Cardiovascular disease Stroke or Brain Injury No Age-Related Impairment Current vision loss may warrant further intervention Currently working with SSB Counselor The senior does not wish to see SSB Send Equipment to? The senior wishes to be contacted by SSB

Notes:



I understand that the information I am prov	viding on this form is for recording and reporting pu	rposes.
The information will be used by MN State	Services for the Blind and	to
create statistical reports that will not identi	ify me as an individual. I understand that I am not re	equired to sign this form.
By not signing this form, I understand that t	the community partner visiting me today is unable t	o leave any low vision
aids and devices with me. This information	will not be released to anyone other than the abov	e-mentioned parties in
any way that will identify me as an individua	al unless SSB is required to do so by court order or l	egislative auditor. For
any other purpose, I will be asked to sign a	separate consent form.	
Signature:		
	Today's	
	Date:	
Printed Name of Customer:		
Verbal Consent Obtained by:	Date:	
<b>Community Partner Information</b> (	(replacement items will be sent here)	
, and an experience of the control o	( op accoment to the control of	
Name of Organization:		
Name of Community Partner:		
Email:		
Phone Number:		
Address:		
	19-5927 or stacy.shamblott@state.mn.us	
Tou can lax of email the form to 031-04	15-5527 of stacy.stranibiottestate.iiii.us	
Manager or Supervisor's Name:		