WORKSITE SCREENING FOR VISION IMPAIRMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
VOCATIONAL REHABILITATION
SFN 682 (2-2023)

Clear Fields

Client Name			Date of Birth
Vision Rehab Specialist Name		Counselor Name	
Diagnosis(es)			
Name of Employer			
Address	City	State	ZIP Code
Contact Name			Telephone Number
Start Date	Number of Hours per Week	Client Financial Contribution VR	
Job Title			
Job Tasks/Duties (attach job description if one was provided)			
Lifting Restriction (per eye examiner)	Other Restriction(s)		

CLIENT INTERVIEW

Date Interviewed	Name of Eye Doctor			Date of Last Exam
Visual Acuity	Copy of the eye report on file? ☐ Yes ☐ No	Low Vision? ☐ Yes ☐ No	Legally Blind? ☐ Yes ☐ No	Blind? ☐ Yes ☐ No

VISUAL HISTORY

Currently wear glasses/contacts? ☐ Yes ☐ No	If yes, how often are contacts worn? ☐ All the Time ☐ Only Reading ☐ Only Driving

History of:
- ☐ Eye Trauma
- ☐ Brain Injury - Date: _____
- ☐ Eye Surgery - Procedure: _____

CURRENT VISUAL PROBLEMS

Diplopia (double vision)
☐ Yes ☐ No If yes, does it disappear if you close an eye? ☐ Yes ☐ No
If yes, which eye is closed to make it disappear? ☐ Right ☐ Left

Can you see clearly when reading? ☐ Yes ☐ No		Can you see objects at a distance (i.e. walking/driving)? ☐ Yes ☐ No	
Can you see clearly when you move your head (side to side or up and down)? ☐ Yes ☐ No		Blurring of vision when looking near to far or far to near? ☐ Yes ☐ No	
Can you see objects near (i.e. reading)? ☐ Yes ☐ No		Unable to keep objects focused? ☐ Yes ☐ No	

Eye pressure, headaches, watery eyes with focusing (eye fatique)?
☐ Yes ☐ No If yes, how long before these symptoms begin? _____
When does it occur? ☐ Reading Print ☐ Using Computer ☐ Both

Do you have problems going from light to dark or dark to light environments? ☐ Yes ☐ No	Do you have sensitivity to light? ☐ Yes ☐ No
Do you need additional light to do tasks? ☐ Yes ☐ No	Do you have a problem with balance? ☐ Yes ☐ No
Is it hard to concentrate or do you have trouble sustaining focus? ☐ Yes ☐ No	
Comments	

GENERAL INTERVIEW QUESTIONS

Have you ever been to ND Vision Services School for the Blind (NDVS/SB)?
☐ Yes ☐ No

If yes, what skills did you work on?

If no, is this something you need to talk with to the client if they need O&M, Braille, new to vision impairment, JAWS training, Smart Phone training, life skills (ADL), etc. Did you provide NDVS/SB Information? ☐ Yes ☐ No

Have you ever had any low vision programming (other than NDVS/SB)?
☐ Yes ☐ No If yes, where:

Describe any assistive technology or accommodations you used in the past that **HAS** worked for you.

Describe any assistive technology or accommodations you used in the past that **HAS NOT** worked for you.

What barriers are you currently experiencing with your job or placement of a job? (Go to Task Performance Limitation Analysis page)

Do you have problems with transportation? ☐ Yes ☐ No	Do you have a driver's license? ☐ Yes ☐ No	Do you use transit? ☐ Yes ☐ No

Explain Other Forms of Transportation (family, friends, Uber, etc.)

Do you have problems finding your way around?
☐ Yes ☐ No If yes, have you had white can training (O&M)? ☐ Yes ☐ No
If no, would the client benefit from white cane training (O&M)? ☐ Yes ☐ No
If yes, is a referral needed for NDVS/SB? ☐ Yes ☐ No

Do you have a smart phone?
☐ Yes ☐ No If yes, do you feel you need more training? ☐ Yes ☐ No
If yes, complete the smart phone attachment and refer to NDVS/SB for additional training.
If yes, is a referral needed? ☐ Yes ☐ No

If you have a smart phone, do you current use low vision apps?
☐ Yes ☐ No If yes, which ones:

Comments

PERSONAL CARE QUESTIONS

Can you complete your activities of daily living independently? ☐ Yes ☐ No	Can you get up on time? ☐ Yes ☐ No
Can you find appropriate clothing for where you are going? ☐ Yes ☐ No Can you see the difference between colors? ☐ Yes ☐ No	
Can you do your own laundry? ☐ Yes ☐ No	Can you make your own meals? ☐ Yes ☐ No
Do you do all your own grooming (i.e. hair, shaving, nail hygiene, etc)? ☐ Yes ☐ No	Are you independent with medication management? ☐ Yes ☐ No
Comments About Personal Care and Home Life	

ON THE JOB TASK PERFORMANCE LIMITATION ANALYSIS

Identify the tasks that are barriers to employment to find AT or accommodations.
** If trialing equipment check the client financial contribution.

	Job Task/Duty	Why is this a problem?	Explain how the task could be done independently. (Explain what has been trialed to provide justification and where the items can be obtained)
1.			
2.			
3.			
4.			
5.			
6.			

OBSERVATIONS FROM ON SITE JOB SCREEN

Observations from Visit

Other Comments