WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Halifax Office
1-800-870-3331 toll free
902-491-8999 local
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Sydney Office
1-800-880-0003 toll free
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Eye Injury Report

WCB Claim #

HCN:

WORKER INFORMATION

Worker's Last Name	First Name	Initial	Date of Birth (dd / mm / yyyy)

Address: Street	City/Town	Province	Postal Code

Home/Cell Phone	Work Phone	Date of Injury (dd / mm / yyyy)

This form must be completed, signed and dated by an eye specialist (ophthalmologist). The following information is required in order to assess the level of impairment, if any, with respect to the worker's traumatic eye(s) injury(s). If you have any questions about this form, please contact the WCB. Please use additional pages if necessary.

A. Please describe the work related injury and indicate the worker's concerns/symptoms.

B. Describe the location and condition of the eye(s), noting any abnormalities of the lid, eyeball, cornea, pupil, vitreous, retina, papilla, etc.

C. How does the present condition affect the usefulness of the eye(s)?

D. Can anything be done to remedy or improve the condition? If so, what treatment or referrals do you recommend?

E. Is the worker at Maximum Medical Recovery in order to proceed with an impairment review? Yes ☐ No ☐

F. If not, please estimate when this will be likely (mm/yyyy):	mm	yyyy

G. Central visual acuity (please report using Snellen 20 ft. equivalent):

Near vision:	(in inches or cm)	Both eyes	Right eye	Left eye
	Without correction			
	With correction			

G. Central visual acuity (continued):

Far vision: (in feet or meters)	Both eyes	Right eye	Left eye
Without correction			
With correction			
Monocular aphakia present		Yes ☐ No ☐	Yes ☐ No ☐
Monocular pseudophakia present		Yes ☐ No ☐	Yes ☐ No ☐
Capsular opacification/deformity		Yes ☐ No ☐	Yes ☐ No ☐
Photophobia		Yes ☐ No ☐	Yes ☐ No ☐

H. Intraocular pressure	mmHG	mmHG
I. Visual fields: Please select normal or abnormal **If abnormal, please provide the plotted graphic chart*	Normal ☐ Abnormal ☐	Normal ☐ Abnormal ☐

J. Diplopia Yes ☐ No ☐ % decrease ocular motility (right) % decrease ocular motility (left)

**If abnormal, please provide the plotted graphic chart or % loss of ocular motility*

K. Any facial/eye disfigurement Yes ☐ No ☐ Degree: Mild ☐ Moderate ☐ Severe ☐

L. Other ocular or adnexal disturbances:

Epiphora: Yes ☐ No ☐ Degree: Mild ☐ Moderate ☐ Severe ☐
Metamorphopsia: Yes ☐ No ☐ Degree: Mild ☐ Moderate ☐ Severe ☐

M. What was the condition of the eye(s) prior to the injury?

N. What changed as a result of the compensable injury?

O. Please estimate what portion of the current deficit or impairment is related to the pre-condition (M) and the condition resulting from the compensable injury (N).

HEALTH CARE PROVIDER INFORMATION (to be completed by health care provider; please print)

Name and Address of Ophthalmologist:

Signature:	Phone:	Fax: