CIVIL AVIATION DEPARTMENT, HONG KONG, CHINA
OPHTHALMOLOGY EXAMINATION REPORT

MEDICAL IN CONFIDENCE

Applicant's details

Surname:	Previous surname(s):		Reference number (if applicable)
Forenames:	Date of birth:	Sex Male ☐ Female ☐	Application Initial ☐ Renewal ☐
HK CAD Licence No:	Class of medical certificate applied for 1☐ 2☐ 3☐		

Consent to release medical information: I hereby authorise the release of all information contained in this report and any or all attachments to HK CAD ("the Authority"), recognising that these documents or electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the Authority, providing that I or my physician may have access to them according to HK law. Medical Confidentiality will be respected at all times.

Date: .... Signature of the applicant: .... Signature of medical examiner (witness): ....

Examination Category	Ophthalmological history:
Initial ☐ Renewal ☐ Special referral ☐	

Clinical examination

Check each item		Normal	Abnormal
Eyes, external & eyelids			
Eyes, Exterior (slit lamp, ophth.)			
Eye position and movements			
Visual fields (confrontation)			
Pupillary reflexes			
Optic fundi			
Convergence	cm		
Accommodation	D		

Ocular muscle balance (in prism dioptres)

Distant at 6 metres	Near at 30-50 cm
Ortho	Ortho
Eso	Eso
Exo	Exo
Hyper	Hyper
Cyclo	Cyclo
Tropia Yes ☐ No ☐	Phoria Yes ☐ No ☐
Fusional reserve testing Not performed ☐	Normal ☐ Abnormal ☐

Colour perception

Pseudo-isochromatic plates	Type:
No. of plates:	No. of errors:
Lantern testing indicated?	Yes ☐ No ☐
Method:	Result:

Visual acuity

Distant vision at 6m

	Unaided	Glasses	Contact Lenses
Right eye			
Left eye			
Both eyes			

Intermediate vision at 1m using N Type

	Unaided	Glasses	Contact Lenses
Right eye			
Left eye			
Both eyes			

Near vision at 30-50 cm using N Type

	Unaided	Glasses	Contact Lenses
Right eye			
Left eye			
Both eyes			

Refraction	Sph	Cylinder	Axis	Near (add)
Right eye				
Left eye				
Note: Refraction to be examined in cycloplegia at initial examination				

Glasses	*Hard/soft contact lenses*
Yes ☐ No ☐	Yes ☐ No ☐
Type:	Type:

Intra-ocular pressure

Right (mmHg)	Left (mmHg)
Method:	Normal ☐ Abnormal ☐

Any corneal operation including laser surgery? Yes ☐ No ☐

If yes, date: ....

type: ....

any of the following:

glare sensitivity or haloing	Yes ☐	No ☐
night vision difficulty	Yes ☐	No ☐
diurnal variation of vision	Yes ☐	No ☐
use of ocular medication	Yes ☐	No ☐
Corneal haze	Yes ☐	No ☐
loss of contrast sensitivity/acuity	Yes ☐	No ☐

Refraction and visual acuity measurements at 3 months post-surgery: ....

Refraction and visual acuity measurements at 6 months post-surgery: ....

Contrast sensitivity measurements at 3 months post-surgery: ....

Contrast sensitivity measurements at 6 months post-surgery: ....

Ophthalmological remarks and recommendations:

Examiner's declaration:

I hereby certify that I have personally examined the applicant named on this medical examination report and that this report with any attachment embodies my findings completely and correctly.

Place and date:	Ophth Examiner's Name and Address: (Block Capitals)	Specialist Stamp:
Specialist's signature:	Telephone No.: Telefax No.:	