MONASH University

AS/NZS 4801 OHSAS 18001 BUREAU VERITAS Certification

VISION REPORT: PRE-COMMENCEMENT OF WORK WITH CLASS 3B OR CLASS 4 LASERS

Full Name:____

Date of Birth: ____

Date of Examination: ____________________________________

Privacy Statement

The information on this form is collected for the primary purpose of providing high quality health care. It may also be used for a related secondary purpose that complies with legislative reporting requirements. The information collected on this form may be disclosed to others involved in your health care and government departments such as the Department of Health and Human Services, as required under mandatory reporting requirements. If all of the information requested is not provided, it may compromise the quality of the health care and treatment given to you, and may not be possible for the university to meet its legal obligations. You have a right to access personal information that Monash University holds about you, subject to any exceptions in relevant legislation. To do this, please contact the Monash University Privacy Officer at privacyofficer@monash.edu. For information about the handling of your personal information, see the HR Privacy Collection Statement for Staff (https://www.monash.edu/privacy-monash/guidelines/collection-personal-information#privacy). For more about Privacy at Monash, see our Privacy Procedure:
https://www.monash.edu/privacy-monash
https://www.monash.edu/__data/assets/pdf_file/0003/790086/Privacy.pdf

Declaration

1. **I understand I should enquire about the examination conditions and requirements (e.g. having eye drops administered which may cause temporary blurriness or glare sensitivity; avoiding driving for at least one hour after examination) when booking my appointment.**
2. **I have read and understood the Privacy Statement.**
3. **I understand that all details within this form relating to medical history, current medical status and personal information will remain confidential.**
4. **I understand that this form will be completed by the clinic which performs the examination. Once complete, this form and my examination results will be forwarded by the clinic to OH&S.**
5. **I understand that my Manager/Supervisor may be notified regarding my examination results.**
6. **I give my consent for my results to be forwarded to relevant parties.**

Signature: ________________________________ **Date:** ________________

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VISION REPORT			
Full name:			
Date of birth:	Date of examination:		
General Health			
Are there any health issues which may lead to a higher level of risk during laser use?		YES	NO
If yes, please describe:			
Medication			
Are any photosensitising medications being taken?		YES	NO
If yes, please list:			
Visual Acuity			
Visual acuity (with glasses if worn):			
Amsler Grid			
Is the Amsler grid result normal?		YES	NO
If no, please describe:			
Colour Vision			
Is colour vision normal?		YES	NO
If no, please describe:			
Ocular Exam			
Are the external ocular examination findings normal?		YES	NO
If no, please describe:			
Are the anterior segments normal under slit lamp examination?		YES	NO
If no, please describe:			
Is the ophthalmology of the optic nerve, macula and peripheral retina normal?		YES	NO
If no, please describe:			
Examiner Details			
Practitioner Name:			
Practice Details:			
Practitioner Signature:	Date:		