

FORM A SCORESHEET

Date _____ Test Print Size _____ M

Practice Sentences (Do Not Add to Score) Yes ✓ No ✓

P1. repay _____ _____ _____
 P2. swim _____ _____ _____
 P3. nothing _____ _____ _____

	1	0	Correct Response	Error Response
1.	<input type="checkbox"/>	<input type="checkbox"/>	ending	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	stand	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	ship	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	cooked	_____
5.	<input type="checkbox"/>	<input type="checkbox"/>	boat	_____
6.	<input type="checkbox"/>	<input type="checkbox"/>	better	_____
7.	<input type="checkbox"/>	<input type="checkbox"/>	melts	_____
8.	<input type="checkbox"/>	<input type="checkbox"/>	long	_____
9.	<input type="checkbox"/>	<input type="checkbox"/>	retains	_____
10.	<input type="checkbox"/>	<input type="checkbox"/>	heavier	_____
11.	<input type="checkbox"/>	<input type="checkbox"/>	salt	_____
12.	<input type="checkbox"/>	<input type="checkbox"/>	have	_____
13.	<input type="checkbox"/>	<input type="checkbox"/>	pieces	_____
14.	<input type="checkbox"/>	<input type="checkbox"/>	waterfall	_____
15.	<input type="checkbox"/>	<input type="checkbox"/>	walk	_____
16.	<input type="checkbox"/>	<input type="checkbox"/>	acceptable	_____
17.	<input type="checkbox"/>	<input type="checkbox"/>	material	_____
18.	<input type="checkbox"/>	<input type="checkbox"/>	safety	_____

Raw Score _____ x 1.266 - 5.066 = **GLE** _____
 (See Appendix D for Conversion Table)

Time to complete test _____ minutes

Comments _____

FORM B SCORESHEET

Date _____ Test Print Size _____ M

Practice Sentences (Do Not Add to Score) Yes ✓ No ✓

P1. hard _____ _____ _____
 P2. scratch _____ _____ _____
 P3. twice _____ _____ _____

	1	0	Correct Response	Error Response
1.	<input type="checkbox"/>	<input type="checkbox"/>	keep	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	outdoors	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	dogs	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	spring	_____
5.	<input type="checkbox"/>	<input type="checkbox"/>	big	_____
6.	<input type="checkbox"/>	<input type="checkbox"/>	knows	_____
7.	<input type="checkbox"/>	<input type="checkbox"/>	gear	_____
8.	<input type="checkbox"/>	<input type="checkbox"/>	age	_____
9.	<input type="checkbox"/>	<input type="checkbox"/>	love	_____
10.	<input type="checkbox"/>	<input type="checkbox"/>	name	_____
11.	<input type="checkbox"/>	<input type="checkbox"/>	feathers	_____
12.	<input type="checkbox"/>	<input type="checkbox"/>	sooner	_____
13.	<input type="checkbox"/>	<input type="checkbox"/>	bad	_____
14.	<input type="checkbox"/>	<input type="checkbox"/>	knob	_____
15.	<input type="checkbox"/>	<input type="checkbox"/>	allow	_____
16.	<input type="checkbox"/>	<input type="checkbox"/>	healthy	_____
17.	<input type="checkbox"/>	<input type="checkbox"/>	countries	_____
18.	<input type="checkbox"/>	<input type="checkbox"/>	breaths	_____

Raw Score _____ x 1.266 - 5.066 = **GLE** _____
 (See Appendix D for Conversion Table)

Time to complete test _____ minutes

Comments _____

MORGAN LVRCA

PERSONAL DATA

Name	Examiner	Record No.
Telephone(s)	Birthdate	
Education Level	Profession/Occupation	
Primary Pathology	Additional Pathologies	
Age at Onset of Visual Impairment	Aided Acuity	

READING BACKGROUND

<p>➤ What type of print did individual read before visual impairment?</p> <p>Continuous text _____</p> <p>Spot reading _____</p>
<p>➤ What type of print does individual read currently?</p> <p>Continuous text _____</p> <p>Spot reading _____</p>
<p>➤ What type of print would individual like to read in future?</p> <p>Continuous text _____</p> <p>Spot reading _____</p>

TEST CONDITIONS

Form A		Form B	
Eye Used <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU		Eye Used <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	
Low Vision Device		Low Vision Device	
Power	Rx Used <input type="checkbox"/> Yes <input type="checkbox"/> No	Power	Rx Used <input type="checkbox"/> Yes <input type="checkbox"/> No
Non-Optical Devices		Non-Optical Devices	
Lighting (<i>type, wattage, distance</i>)		Lighting (<i>type, wattage, distance</i>)	
Focal Distance	Test Print Size _____ M	Focal Distance	Test Print Size _____ M
Direction of EV <input type="checkbox"/> 12:00 <input type="checkbox"/> 1:30 <input type="checkbox"/> 3:00 <input type="checkbox"/> 4:30 <input type="checkbox"/> 6:00 <input type="checkbox"/> 7:30 <input type="checkbox"/> 9:00 <input type="checkbox"/> 10:30		Direction of EV <input type="checkbox"/> 12:00 <input type="checkbox"/> 1:30 <input type="checkbox"/> 3:00 <input type="checkbox"/> 4:30 <input type="checkbox"/> 6:00 <input type="checkbox"/> 7:30 <input type="checkbox"/> 9:00 <input type="checkbox"/> 10:30	