Stereopsis Test

Date of test: _____ dd / mm / yyyy

PATIENT INFORMATION

Name: _____ **Date of birth:** _____ dd / mm / yyyy

Contact information: _____

Disclaimer: There are different ways to test stereopsis, and each test differs in terms of procedures, equipment used, and results. Choose the appropriate test that best suits your patient's concern.

PROCEDURE

Choose the appropriate test to do below. Prepare the equipment for the test. Prepare the patient. Administer the test accordingly. Record results on tests administered accordingly.

METHODS OF STEREOPSIS TESTS

Test 1 - Administered?

◯ Yes ◯ No

Test 1 - Results:

Test 2 - Administered?

◯ Yes ◯ No

Test 2 - Results:

Test 3 - Administered?

◯ Yes ◯ No

Test 3 - Results:

Test 4 - Administered?

◯ Yes ◯ No

Test 4 - Results:

Test 5 - Administered?

◯ Yes ◯ No

Test 5 - Results:

Test 6 - Administered?

◯ Yes ◯ No

Test 6 - Results:

Test 7 - Administered?

◯ Yes ◯ No

Test 7 - Results:

Test 8 - Administered?

◯ Yes ◯ No

Test 8 - Results:

Indicate below: _____

Results (if administered):

RESULTS AND FINDINGS

Overall stereo acuity: _____

Observations:

Additional notes:

HEALTHCARE PROFESSIONAL INFORMATION

Name: _____ **License ID number:** _____

Contact information: _____

Signature:
Date of test: _____ dd / mm / yyyy