

Low Vision Evaluation: Clinical Considerations

Key principles from Dr. Shuldiner's presentation

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A low vision evaluation is more than a measurement of visual acuity. It requires understanding what a patient wants to accomplish, identifying the barriers to those activities, and applying clinical judgment to determine which approaches may provide meaningful functional improvement.

What changes in a low vision evaluation?



Allow sufficient time.

A comprehensive evaluation generally requires at least an hour. Rushing can leave important functional needs unexplored.



Focus on function.

Medical findings and visual measurements remain important, but the evaluation must also address how the patient uses vision in everyday life.



Use appropriate low vision testing methods.

Conventional Snellen charts may not adequately characterize the vision of a low vision patient. Appropriate charts and testing procedures are essential.



Analyze the task.

Understanding the activity, working distance, environment, and patient's goals helps guide the choice of an appropriate solution.



Apply optical knowledge.

Effective use of telescopes, microscopes, and other magnification approaches requires more than selecting a magnification power.



Consider illumination and glare.

Lighting conditions can substantially influence functional performance and should be considered as part of the evaluation.

Questions that uncover the patient's goals

A case history should help the doctor understand the person behind the diagnosis.

- 1 Diagnosis** What is the diagnosis, and what has the patient been told about their vision?
- 2 Occupation** What is the patient's present or former occupation, and which activities remain important?
- 3 Support** What family or other support is available?
- 4 Driving** Is the patient still driving? What concerns or goals do they have related to driving?
- 5 Wish list** What would the patient most like to be able to do again—or do more easily?

Clinical reminder: The more complete and specific the wish list, the clearer the functional purpose of the evaluation.

Common pitfalls—and the judgment they require

Common pitfall	Clinical consideration
Overmagnifying	More magnification is not necessarily a better solution. Does it help the patient accomplish the intended task?
Failing to listen	Have I understood what the patient wants, rather than assuming what they need?
Rushing the examination	Have I allowed enough time to explore the patient's functional goals and responses?
Prescribing by formula	Have I evaluated the individual patient's response rather than relying on a calculation alone?
Skipping task analysis	Do I understand the task, working distance, and environment before recommending a solution?

Three principles to carry into practice



Demonstrate, don't just describe.

Have sufficient demonstration options available to explore appropriate solutions with the patient.



Make the wish list as complete as possible.

The patient's priorities should guide the evaluation and help define success.



Verify before ordering.

Be certain that the proposed device works for the patient in the intended task before placing an order.

A patient example: When knowledge changes the outcome

A patient was distraught after being told they could not meet their state's vision requirements for driving. A low vision doctor familiar with the applicable rules and reporting process was able to provide the appropriate vision report documenting findings that met the requirements. The patient was relieved to learn that the earlier conclusion had not been the final answer.

The lesson: Clinical knowledge extends beyond measurement. Understanding the patient's goals, the applicable requirements, and how to interpret and document findings can make a meaningful difference.

Driving eligibility and reporting requirements vary by jurisdiction. Clinicians should verify the applicable rules and avoid promising eligibility.

From principles to practice

The principles are only the beginning. Applying them effectively requires clinical judgment, hands-on experience, and the ability to adapt the examination and recommendations to each patient.

This reference highlights selected considerations from Dr. Shuldiner's CE presentation. It is not a substitute for comprehensive clinical training or the full 12-Step Low Vision Evaluation.

Interested in learning to put these principles into practice?

Learn more about the hands-on training and ongoing support offered by the Shuldiner Low Vision Training Institute.

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