Vision Screening & Referral Form

Dear Provider:
Below are the results of the school vision screening on the student named above. Please complete the Eye Care Specialist Report and return the completed form to the school nurse listed above. A request is also made that you provide the parent/guardian with a copy of the report.

School Screening Report

1st Date screened □ With correction □ Without correction
2nd Date Screened □ With correction □ Without correction

Distance Visual Acuity:
R 20/____ L 20/____

Ocular Alignment (Random Dot E/Stereotest)
□ Pass □ Fail □ Did Not Test

Color Vision
□ Pass □ Fail □ Did Not Test

Clinical Observation Notes

Eye Care Specialist Report

Date of Exam: Overall Findings:
□ Normal exam, no glasses needed □ Significant refractive error, glasses needed
□ Strabismus □ Amblyopia □ Other (please specify):________________

Distance Visual Acuity: Without Correction With Current Prescription With New Prescription
R_______ L_______ R_______ L_______ R_______ L_______

Cycloplegic refraction is recommended for all children.
Agent used: □ Cyclopentolate □ Tropicamide □ None
Was a prescription for glasses given? □ Yes □ No

Cycloplegic Refraction Vision Glasses Prescription Given
Sphere Cylinder Axis Sphere Cylinder Axis
OD OS

Do you need to see this child again? _________ When?__________________________

Recommendations (other than glasses):
□ Patching □ Atropine drops □ Referral to pediatric specialist □ Other (specify):________________________

Eye Specialist: __________________________ Date: __________________________
Office Phone Number: __________________________ Office Address: __________________________