Vision Screening & Referral Form

School Nurse Name: _____

Phone # _____

Fax# _____

School Name: _____

Student Name: _____

DOB: _____ Grade: _____

Health Insurance: Y N Vision Insurance Plan: Y N

Medicaid: Y N Medicaid Eligible: Y N

Other Vision Financial Support: _____

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 **Distance Visual Acuity:** R 20/_____ L 20/_____	**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** R_____ L_____	**With Current Prescription** R_____ L_____	**With New Prescription** 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: _____