Division of Services for the Blind & Visually Impaired
Utah State Office of Rehabilitation
250 North 1950 West #B, Salt Lake City, Utah 84116-7902

VISION SCREENING REFERRAL FORM

Dear Doctor:
The child whose name appears below was vision screened by approved vision screeners and refered for an eye examination for the reason(s) checked:

- ☐ Could not see the line on the chart appropriate for child's age
- ☐ Difference in visual acuity between eyes
- ☐ Possible muscle imbalance
- ☐ Symptoms
- ☐ Failed MTI photoscreening or Suresight device screening

Vision screening is not a substitute for a complete eye exam and vision evaluation by an eye doctor

It will be greatly appreciated if you will complete this report of your findings and mail **BOTH** copies to the address in the bottom left hand portion. Your cooperation in providing this information is appreciated. Your cooperation in providing this information will be helpful in evaluating the merits of this program.

Portions below to be completed only by school nurse:

Child's Complete Name: DOB: Grade: Gender:

Parent/Guardian's Name:

Mailing Address: City/State: Zip:

Screening location (school/head start/health dept): District Located in: Screening date:

EYE EXAMINER'S REPORT

CONFIDENTIAL - for statistical purposes only

VISUAL ACUITY

	WITHOUT CORRECTION	WITH CORRECTION
RIGHT EYE	20/	20/
LEFT EYE	20/	20/
BOTH EYES	20/	20/

DIAGNOSIS

Did you find a condition requiring observation, treatment, or correction? ☐YES ☐NO If YES, please complete information below where appropriate:

REFRACTIVE ERROR:
☐NO ☐YES Hyperopia RE ☐ LE ☐ Diopters _____ _____ Myopia RE ☐ LE ☐ Diopters _____ _____ Astigmatism RE ☐ LE ☐ Diopters _____ _____

MUSCLE IMBALANCE: ☐NO ☐YES Tropic RE ☐ LE ☐ Type:

AMBLYOPIA: ☐NO ☐YES Tropic RE ☐ LE ☐

Presently under eye doctor care for (please specify):

RECOMMENDATIONS

Were glasses prescribed? ☐NO ☐YES If yes, safety lenses? ☐ No ☐ Yes
Return for follow up exam: ☐NO ☐YES If yes, when:

Comments / Other Diagnosis (please specify):

ATTENTION DOCTOR: Please do not detach. Send both copies to:

Examination Date _____

Examiner's Name Degree

Examiner's Address

REF R2011