Vision Screening Referral

Name of Pupil School Grade Age

Name & Address of Parent/Guardian Date

Parent: Your child had some difficulty with a recent school vision screening and should be examined by an eye specialist (Ophthalmologist or Optometrist) of your choice.

Reason for Referral
1. Visual Acuity: R____ L____
2. +1.75 Lens: R____ L____
3. Muscle Balance: F____ N____
4. Binocularity _____
5. Color Blindness _____
6. Photoscreen Referral _____

Screened with Glasses Yes____ No____ Referred by: _____

Please ask that this form be completed and mailed to the address in the lower left corner.

Vision Examination Report

Vision Acuity Without Glasses	Distance: R____ L____	Near: R____ L____
Vision Acuity With Glasses	Distance: R____ L____	Near: R____ L____
Type of Refractive Errors	Right_____	Near_____
Other Ocular Defect or Disease	Right_____	Near_____

Comments or Recommendations: _____

Referred for Treatment: Yes____ No____ Use of Glasses: Constantly _____ Close Work Only _____

Please check the appropriate statement based on your professional diagnosis.

___Although a vision impairment exists, this impairment has been corrected to the extent possible and should not interfere with individual intellectual, academic, and speech/language evaluation.

___This child is experiencing a visual impairment to the degree that he/she would require specialized evaluation. This specialized evaluation should include _____.

___Although a vision impairment exists, it has been corrected with glasses and should not interfere with intellectual, academic, and speech/language evaluation when wearing glasses.

___This child is not experiencing any visual impairment that might interfere with individual intellectual, academic, and speech/language evaluation.

Date of this examination:_____ Date of next examination:_____

RETURN TO:

_____ _____
Examiner's Name Degree

_____ _____
Address

_____ _____

08/2012