Eye Care Provider Evaluation Sheet

This patient has been referred to you for a complete pediatric eye exam after failing a Lion's Club eye screening. **In addition to performing a cycloplegic refraction, this form (COMPLETELY FILLED OUT BY THE EXAMINING EYE DOCTOR) must be returned to Operation KidSight by fax (317) 220-8585 or e-mail kidsight@att.net.** Alternatively, you may mail the form to Operation KidSight, 8780 Purdue Rd., Suite 5, Indianapolis, IN 46268. Medical questions may be directed to the KidSight Medical Director, Daniel E. Neely M.D. at deneely@iupui.edu.

Child's Name:_____ Date of Birth:_____

Date of Vision Screening:_____ City of Screening:_____

Session No._____

(To be completed by MD/OD)

Date of Exam:_____

Name of reporting MD/OD:_____ Telephone number:_____

Visual Acuity: OD:_____ OS:_____ Anisocoria: yes/no

Method of testing vision (Circle all that apply)

a. Snellen letters b. Allen figures c. HOTV d. E-game/Broken circle

e. CSM/F & F f. Others (please elaborate)

Method of Assessing Alignment (circle all that apply): Penlight Exam Cross-Cover Testing

Ocular Alignment: Ortho:_____ Strabismus (please elaborate):_____

Cycloplegic Refraction: Please perform a dilated examination and cycloplegic refraction on all patients.

Agent (circle one): Cyclogyl 1% Cyclogyl 2% Mydriacyl 1% None

Refraction: OD: _____ _____ X _____

OS: _____ _____ X _____

Diagnosis of Amblyopia: Yes No

Amblyogenic Factors: Strabismus:____ Anisometropia:_____ Media Opacity:_____ Other:_____

Treatment: None_____ Glasses:_____ Other (please specify):_____

Follow-Up: None_____ Yes_____ Date: _____

Fax: (317) 220-8585 **Email: kidsight@att.net**

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