Physicians: Please complete and fax to the KidSight Program 855-829-5950

Physician Evaluation Sheet

This form provides valuable data for our program

Child's Name: ____ **Date of Birth:** _______________________

Session # ___________*Date of Screening:* ____________ *Place of Screening*_______________________________

EYE CARE PROFESSIONALS: This patient has been referred to you for a complete pediatric eye exam after failing a Lions vision screening. In our efforts to maintain grant funding for this valuable service we would greatly appreciate your time in filling out this form and faxing to: 855-829-5950 (parents/guardians sign a release prior to the screening but if you require a signature in your file, the parents can sign below). Please call 720-325-7078 with any questions.

PARENTS/GUARDIANS: Your doctor may require this release of information for their records:

I will allow this release of information to the Colorado Lions KidSight Program and understand it is kept confidential:

____ ______________________________

Signature Date

To be completed by MD/OD:

1) Date of Exam: ____

2) Name of Reporting MD/OD: ____

3) Visual Acuity: OD: ____________________ **Visual Acuity: OD:**___________________________
(At time of visit) OS: ____________________ **(with correction) OS:**___________________________

4) Method of Testing (Circle all that apply)

- **a) CSM**
- **b) F & F**
- **c) HOTV**
- **d) E-game**
- **e) Picture (Snellen equivalent)**
- **F) Other - Please elaborate**______________________________

5) Method of Assessing Alignment (circle all that apply): Penlight exam Cross-over testing

6) Ocular Motility

Ortho: ___________________________ **Strabismus:** _____________________________

7) Cycloplegic Refraction

Agent: Cyclogyl 1% Cyclogyl 2% Other: ______________________

Refraction:

OD _____+_____x______ **Or OD**_____-_____x______

OS _____+_____x______ **Or OS** _____-_____x______

8) Diagnosis:

Amblyopia: Yes _____ **No** _____

Amblyogenic factors:

Strabismus: ___________ **Anisometropia:**__________ **Media Opacity:**___________

Anisocoria: ___________ **Other:** ____

9) Treatment: None: _____ **Glasses:**_____ **Other (Please specify):** ___________________

10) Follow-up: None: _____ **Other (Include date):** _________________________________

Please mail to: Colorado Lions KidSight Program, 8200 S. Quebec St. #A3-704, Centennial, CO 80112 Or fax to 855-829-5950.