

# Referral for an Eye Examination

January 24, 2014

Dear Parent/Guardian:

We routinely screen vision to identify children who have vision problems or might be at risk for vision problems. We refer children for an eye exam when they do not pass vision screening or are at risk of a vision problem because of a medical or developmental reason. Vision screening does not replace a complete eye exam, but it might suggest a referral to an eye doctor for a comprehensive eye exam.

**You are receiving this document because your child** First, M.I., Last **had his/her vision screened or should have an eye exam because of a medical or developmental risk for a vision problem and needs a complete eye exam with an eye doctor (an optometrist or an ophthalmologist.)** It is important to schedule this exam as soon as you can. Do not miss this appointment. If the eye doctor finds a vision problem, early treatment leads to the best possible results for your child's vision. The back of this form lists the reason(s) for this referral.

The back of this page lists the reason(s) for this referral. Please:

- Complete the Consent and Release of Information block below AND the top part of the back of this page.**
- Take this paper with you to the eye exam and give the form to your eye doctor.**
- Ask the eye doctor to send exam results to us and discuss the eye exam results with us, if necessary.**

If you need help finding a local eye doctor for your child's appointment, use the website links below. Many programs help cover all or part of eye care expenses for children. Let us know if you want information about these programs.

Sincerely,

[Referring primary care provider, school nurse, Head Start staff, Other, ]

[Practice/Office/School/Agency name and address ]

## Consent and Release of Information

By my signature below, I authorize: (1) the vision screening agency to release my child's vision screening results and/or medical or developmental reason for an eye exam to the eye doctor and medical doctor (if screening did not occur in the medical home), (2) my child's eye doctor to send exam results to the vision screening agency, (3) the vision screening agency and eye doctor to discuss eye exam results, (4) and the vision screening agency to send exam results to the child's medical doctor (if screening did not occur at the medical office) for the specific purpose of notifying my child's healthcare and educational providers of any specific vision problems, recommendations, and treatment instructions related to my child's vision needs. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain an eye exam for my child or assistance with payment for the eye exam.

\_\_\_\_\_  
(Signature of parent/guardian)

\_\_\_\_\_  
(Date)

## Find an eye doctor near you:

- American Academy of Ophthalmology: [www.aao.org/find\\_eyemd.cfm](http://www.aao.org/find_eyemd.cfm)
- American Optometric Association: [www.aoa.org](http://www.aoa.org)
- Centers for Medicare and Medicaid Services: [www.medicare.gov/physiciancompare](http://www.medicare.gov/physiciancompare)
- American Association for Pediatric Ophthalmology and Strabismus: [www.aapos.org](http://www.aapos.org)
- All About Vision: [www.allaboutvision.com/eye-doctor](http://www.allaboutvision.com/eye-doctor)
- College of Optometrists in Vision Development: [www.covd.org](http://www.covd.org)

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**Patient information:** Name (First, M.I., Last) \_\_\_\_\_  
 Birth date (MM/DD/YYYY) \_\_\_\_\_ Sex (M/F)  Male  Female Grade \_\_\_\_\_ Primary language \_\_\_\_\_  
 Parent or guardian \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary phone ( ) \_\_\_\_\_ - \_\_\_\_\_ (select type)  MOBILE  HOME If mobile, text messages allowed (Y/N) \_\_\_\_\_  
 Secondary phone ( ) \_\_\_\_\_ - \_\_\_\_\_ (select type)  MOBILE  HOME If mobile, text messages allowed (Y/N) \_\_\_\_\_

**Referring agency contact information and reason for referral:**

Office name \_\_\_\_\_ Phone number ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Fax number ( ) \_\_\_\_\_ - \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Date of referral \_\_\_\_\_ Vision screening conducted by \_\_\_\_\_

Reason for referral (Check all that Apply):

- Visual acuity ( \_\_\_ Distance \_\_\_ Near \_\_\_ Both)
- Misaligned eyes
- Pupillary reflex
- Red reflex
- Ocular structure concern (i.e., ptosis (drooping eyelid))
- Family history of early onset vision problems
- Developmental delay/chronic condition (describe) \_\_\_\_\_
- Other (describe) \_\_\_\_\_

Additional comments:

**Exam results from the eye doctor:**

Date of eye examination: \_\_\_\_\_

Best visual acuity		Info Vision Screening Agency Should Know/Do
Right	Left	
_____	_____	

**Check if appropriate:**

- Treatment recommended
  - Medical: \_\_\_\_\_
  - Glasses
  - Contact Lenses
  - Other: \_\_\_\_\_
- Corrective lenses prescribed
  - Constant wear
  - For near only
  - For distance only
- Hyperopia
- Myopia

- Astigmatism
- Anisometropia
- Amblyopia
  - Patching recommended \_\_\_\_\_ hrs daily
- Strabismus
- Low vision evaluation/assistance recommended
- Re-examination advised
  - With 6 months
  - Within 12 months
  - Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**Eye Care Provider contact information:**

ECP Name \_\_\_\_\_ Phone( ) \_\_\_\_\_ - \_\_\_\_\_ Fax ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Eye Care Provider – Please return completed form to Referring Agency