



## Vision Screening Report

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Screening Site: \_\_\_\_\_ Date of Screening: \_\_\_\_/\_\_\_\_/\_\_\_\_

This letter is to inform you that your child **did not pass** the vision screening.

The screening was performed using a SPOT vision screener. After taking various measurements of the eyes, our results show that your child has a vision problem with:

- Myopia (*near sightedness*)
- Hyperopia (*far sightedness*)
- Gaze/Strabismus (*misaligned eye*)
- Astigmatism (*problem focusing*)
- Anisometropia (*unequal power*)
- Anisocoria (*unequal pupil size*)
- Other \_\_\_\_\_

**Your child requires an appointment with an EYE doctor for a full eye examination.** If left untreated, the above condition could cause permanent vision loss and limit the ability to learn and succeed in school.

Pediatricians do not have the proper equipment or expertise to perform eye exams or treat eye conditions, therefore your child needs to be seen by an EYE doctor. **Because not all eye doctors will see children under the age of eight (8), please visit our website for a list of eye doctors in your area and make an appointment for your child. Please take this form with you to the eye exam.** The information will help the eye doctor know why your child did not pass our screening. The eye doctor will complete the back of this form and return it to our office. This helps us to measure the accuracy and success of our vision screening program.

We will be in touch with you soon to see how your child's vision is progressing. We cannot close your child's case until an eye exam has been obtained.

**Thank you for working with us to ensure your child's healthy development!**

### For more information about your child's GROW Check and resources:

- Visit the Family Portal
- Email: [support@getreadytogrow.org](mailto:support@getreadytogrow.org)
- Phone: (585) 295-1008; Fax: (585) 295-1090
- Visit [www.GetReadyToGROW.org](http://www.GetReadyToGROW.org) for a list of vision providers



Dear Doctor,

Based on our results using the SPOT vision screening device, the child listed below is being referred for a complete eye examination in order to rule out any potential vision problems. **Please have the parent sign below and fax this form to Get Ready to GROW at (585) 295-1090 with your professional findings.** Thank you for helping us prevent vision loss for the children in our community!

I hereby give the eye doctor listed below permission to fax my child's eye report to Children's Institute

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Parent/guardian signature

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Screening Site: \_\_\_\_\_ Observations: \_\_\_\_\_

Date of Screening: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Results of Complete Eye Exam**

Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Diagnosis**

- Normal Exam – no concern
- Hyperopia
- Myopia
- Astigmatism
- Amblyopia
- Strabismus
- Anisocoria
- Anisometropia
- Other: \_\_\_\_\_

**Refraction**

OD: \_\_\_\_\_  
 OS: \_\_\_\_\_

**Treatment**

- Glasses  YES  No
- Patching
- Surgery
- Observation: F/U in 6 months or less
- Observation: F/U 1 year
- Other: \_\_\_\_\_

**Comments**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Examining Doctor Information**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Fax: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please FAX this completed form to: (585) 295-1090 • Attn: Get Ready to GROW

