Vision referral form

Utah Department of Health and Human Services in accordance with UCA 53G-9-404

Student name:	***Date of birth:*** ***Grade:***
School name:	***Address:***
Phone:	***Fax:***
Parent/guardian name:	***Parent phone/email:***
School contact:	***Phone/email:***

Date of referral: _____

School vision screening results: *A screening is not a substitute for a complete eye exam and vision evaluation by an eye doctor*

Screening component tested	*Pass*	*Refer*	*Not tested*	*Screening values or notes*
Distance visual acuity	☐	☐	☐	*Uncorrected:* ***Right eye: 20/_____*** ***Left eye: 20/_____***
Two-line acuity difference	☐	☐	☐	*Refer if difference is ≥ 2 lines between eyes (e.g. 20/20 vs 20/32)*
Near visual acuity	☐	☐	☐	*Uncorrected:* ***Binocular: 20/_____***
Tracking	☐	☐	☐	☐ *Smooth and consistent* ☐ *Jerky / uneven movement*
Convergence	☐	☐	☐	☐ *Normal alignment* ☐ *Breaks focus ≥ 4 inches from nose*
Color vision	☐	☐	☐	*Informational screening for classroom adjustments only*

**Utah distance thresholds: 3 years old (20/50) | 4 years old (20/40) | 5 years and older (20/32)*

Reason(s) for this referral:

- ☐ *Did not pass visual acuity (distance /near)*
- ☐ *Convergence, tracking or readily recognized eye abnormality (such as strabismus, ptosis)*
- ☐ *Known diagnosis of neurodevelopmental disorder (such as hearing impairment, cognitive impairment, autism spectrum disorder, speech delay)*
- ☐ *Systemic disease known to have an associated eye disorder (such as diabetes)*
- ☐ *Family history of vision problems*
- ☐ *Special education referral / below benchmark reading assessment*
- ☐ *Other (specify):* _____

Consent and release of information authorization: *By my signature below, I authorize: (1) my student's eye care professional to send exam results to the school, (2) the designated vision point-person (DVPP) and the eye care professional to discuss eye exam results, and (3) for the designated vision point-person to notify the school of any specific vision problems and recommendations related to my student's specific 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 student.*

Parent/guardian signature:_____ ***Date:*** _____

Comprehensive eye exam results

To be completed by the eye care professional in accordance with UCA 53G-9-404

Student name:	***Date of birth:*** ***Grade:***
Parent/guardian:	***Phone/email:***
Eye care professional date of exam:	***Clinic name:***

1. Visual acuity results

- *Distance acuity WITHOUT correction:* *Right eye: 20/_____* *Left eye: 20/_____*
- *Distance acuity WITH correction:* *Right eye: 20/_____* *Left eye: 20/_____*
- *Near acuity WITHOUT correction:* *Right eye: 20/_____* *Left eye: 20/_____*
- *Near acuity WITH correction:* *Right eye: 20/_____* *Left eye: 20/_____*

2. Binocular vision and ocular health

- *Convergence:* ☐ *passed / normal* ☐ *concern noted* ☐ *not tested*
- *Ocular tracking / motility:* ☐ *passed / normal* ☐ *concern noted* ☐ *not tested*
- *Internal/external eye health:* ☐ *passed / normal* ☐ *concern noted:* _____

3. Diagnosis and treatment recommendations

☐ *No functional vision or ocular health problems identified upon exam.*

☐ *Amblyopia diagnosed or suspected*

☐ *Treatment recommended:* ☐ *Glasses prescribed* ☐ *Contact lenses prescribed* ☐ *Patching therapy*

Other treatment / diagnosis (specify): _____

Corrective lens wear recommendations for school:

☐ *Constant wear (To be worn at all times during the school day)*

☐ *Near work only (Reading, classroom writing, desk activities, computer/tablet use)*

☐ *Distance work only (Seeing the board, assemblies, athletic activities)*

☐ *Remove for physical education (PE) or sports (Safety or contact risk protection precautions)*

4. School recommendations

☐ *Preferential classroom seating (e.g., placement close to front instruction boards)*

☐ *Large print materials or high-contrast reading text surfaces*

☐ *Structured visual rest breaks during prolonged near-work or screen tasks*

☐ *Color vision adjustments required*

☐ *Significant vision impairment exists- I recommend referral for a functional vision assessment from a teacher of the visually impaired, either through the local education agency or the Utah Schools for the Deaf and Blind.*

5. Additional notes or recommendations: _____

_____

Recommended return visit / Re-evaluation date: _____

Eye care professional contact information and signature

Provider name:		***Credentials:***
Clinic address:		
Clinic phone:	***Clinic fax:***	
Provider signature:		***Date:***