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|  Section 1 - Details of child |
| Child’s name |  |
| D.O.B |  |
| School |  |
| Date of test |  |



**Results of your child’s vision assessment**

We hope the following information is useful. We have used the information you gave us about your child and the results we obtained when testing their eyes, to describe their vision.

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| **Section 2 - Additional detail about the eye test** |
| Who was present at the eye test? |  |
| What was already known about eyes and vision?Did anyone have questions about eyes and vision? |  |
| **Section 3 – Summary: The child’s eyes and vision** |
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| **Actions from today’s test:** |
| Glasses needed Modifications to classroom/ schoolwork needed  Statement of Educational Need should include information about vision needsChild is eligible for certification as visually impaired GP Action required Another specialist needs to see this child  |

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| **Section 4 – We tested to see if glasses are needed** |
| This was tested: Yes [ ]  No [ ]  This was difficult to assess today [ ] We measured for **focusing accuracy**:This was tested: Yes [ ]  No [ ]  This was difficult to assess today [ ] **Details:.**We gave a new prescription for glasses: Yes [ ]  No [ ]   |

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| **Section 5 – Results of the vision tests we did today** |
| **Visual acuity:** describes how well a person sees black on white detail with glasses if needed. |
|  We were able to measure visual acuity for looking at things: in the distance [ ]  close up [ ]  both were difficult to test today [ ]  |
| **Binocular vision and eye movements:** This is how well your child’s eyes work together |
| This was tested today: Yes [ ]  No [ ]  This was difficult to assess today [ ]  **Details:** |

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| **Visual Field:** This is how well your child can see things to the side of their central vision |
| This was tested today: Yes [ ]  No [ ]  This was difficult to assess today [ ] **Details:** |
| **Contrast Sensitivity**: This is how well objects are seen against different backgrounds |
| This was tested today: Yes [ ]  No [ ]  This was difficult to assess today [ ] **Details:** |
| **Evidence of Cerebral Visual Impairment (CVI):** This is when there are visual difficulties caused by problems in the brain rather than the eyes. |
| This was tested today: Yes [ ]  No [ ]  This was difficult to assess today [ ] **Details:**  |

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| **Section 6 – Results of the eye health check** |
| This was tested today: Yes [ ]  No [ ]  This was difficult to assess today [ ] Does the child need to see another specialist about their eye health? Yes [ ]  No [ ]  **Details:**  |

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| **Section 7 – Technical details for other health professionals** |
| **Visual Acuity** | *[Include distance test used here]* |  |
| *[Include near test used here]* |  |
| **Refractive Error** | *[Include test used here]* |  |
| **Accommodative Function** | *[Include test used here]* |  |
| **Ocular Posture and Eye Movement** | *[Include test used here]* |  |
| **Contrast**  | *[Include test used here]* |  |
| **Visual Field** | *[Include test used here]* |  |
| **Eye Health Exam** | *[Include test used here]* |  |
| **Stereopsis****Colour Vision****CVI** | *[Include test used here]* |  |
| *[Include test used here]* |  |
| *[Include test used here]* |  |
| **Section 8: Assessors** |
| Whom is this report from? Name: Role: Address: Who is getting a copy of this report?  |