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| --- |
|  Section 1 - SIGHT TEST DETAILS |
| Child’s name |  |
| D.O.B |  |
| School |  |
| Date of test |  |

[Enter practice details/address here]

**RESULTS OF YOUR CHILD’S EYE TEST**

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| **Section 2 - Additional detail about the eye test** |
| Who was with the child 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** |
|  |
| **Actions from today’s test:** |
| Glasses needed Modifications to classroom/ schoolwork needed   |

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| 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  |
| 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 prescription for glasses: Yes [ ]  No [ ]

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  **R****I****G****H****T** |  | **Sph** | **Cyl** | **Axis** | **Prism** | **Sph** | **Cyl** | **Axis** | **Prism** | **L****E****F****T** |
|  Dist |  |  |  |  |  |  |  |  |
|  Near |  |  |  |  |  |  |  |  |

What are these glasses for? |

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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 [ ] The vision results were: |
| **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: |
| **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: |
| **Cerebral Visual Impairment (CVI):** This is when there are visual difficulties caused by problems in the brain rather than the eyes. |
| Signs of CVI |

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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:  |
| **Section 7 – Technical details for other health professionals** |
| **Visual Acuity** | **[Enter test details here]** |  |
| **Refractive Error** |  |  |
| **Accommodative Function** |  |  |
| **Ocular Posture and Eye Movement** |  |  |
| **Contrast Sensitivity** |  |  |
| **Visual Field** |  |  |
| **Eye Health Exam** |  |  |
| **Stereopsis****Colour Vision****CVI** |  |  |
|  |  |
|  |  |
| **Section 8: Assessors** |
| Whom is this report from? Name: Role: Address: Who is getting a copy of this report? [ ]  Permission has been given to share this report with stakeholders involved in the child’s care.  |