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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**

|  |  |
| --- | --- |
| **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 | |

|  |
| --- |
| Statement of Educational Need should include  information about vision needs  Child 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: |
| **Evidence of Visual Processing difficulties:** This is when there are visual difficulties caused by problems interpreting visual information in the brain rather than the eyes. |
| This was tested today: Yes  No  This was difficult to assess today  Details: |

|  |  |  |
| --- | --- | --- |
| **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**  **Visual Processing** |  |  |
|  |  |
|  |  |
| **Section 8: Assessors** | | |
| Who 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. | | |