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

Enter hospital/practice/optometrist details here

**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** |
| Include here strengths and limitations e.g. NAME worked really hard today. Our tests show that NAME’s eyes are healthy and he uses his two eyes together in a coordinated way. NAME needs glasses. They should be worn all the time and will help him see better. However, even with the glasses on his high and low contrast vision is reduced and this needs to be considered in the classroom or he will miss out on important information. |
| **Actions from today’s test:** |
| Glasses needed Modifications to classroom/ schoolwork needed  Statement of Educational Need should include information about vision needse.g. Reading and writing materials need to be larger and **bolder** We have included examples of the size of letter/pictures/PECs NAME can easily see as a guide for you. A soft dark pencil (e.g. 8B) or a black marker pen should help NAME with writing/drawing. Black on white information will be more visible than grey or pale colours on white. Presenting one thing at a time (isolated presentation) is importantNAME needs to sit close to the smartboard and be allowed to get close to what he needs to see.Child is eligible for certification as visually impaired GP Action required Another specialist needs to see this child  Insert here clear instructions for GP for referral or action required by another professional with regard to this child, including QTVIE,g, We found evidence for cerebral visual impairment and NAME would benefit from assessment and input from a QTVI |

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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:**  Summary of accomm result and how it relates to refractive error e.g. NAME does not focus accurately on near objects when she is not wearing glasses. This problem may be solved by the glasses that we are going to give NAME and we will assess her focus again when she is wearing them.We gave a new prescription for glasses: Yes [ ]  No [ ]  **Details:** Summarise what glasses are for and when they should be worn.  |

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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 [ ] Technical details of vision testse.g. no formal measure of vision possible.Where formal measure obtained include here e.g. R and L 0.2logMAR @3m with glassesNAME has extremely limited vision. He responds to light and dark, but we do not think he consistently sees shapes and detail. We have included examples of what NAME should be able to see clearly.  |
| **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:**  e.g. NAME’s left eye turns in. This is a long-standing eye turn (squint) and does not require action. Because the left eye turns in NAME uses her right eye to see and she does not have 3D vision.  |

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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:**  e.g. NAME does not see things to the right side of his vision. This ties in with the weakness on the left side of his body. |
| **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:**  e.g. NAME’s low contrast vision is poorer than expected for his age. |
| **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:** Detail results of visual perceptual tests/parental questioning. Include strategies where appropriate.  |

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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:**  e.g. NAME has a cataract in his left eye. This has not been noticed before and he needs to see an ophthalmologist (eye doctor) about this. |

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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****Visual Processing** | *[Include test used here]* |  |
| *[Include test used here]* |  |
| *[Include test used here]* |  |
| **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. |