

TAKING A LOOK! CHECKLIST
A FIRST STEP IN VISION ASSESSMENT FOR OHIO'S INFANTS AND TODDLERS

Date: _____ County: _____

I. BACKGROUND INFORMATION

Child's Name: _____ DOB: _____

Eye Doctor: _____ Seen in last year? _____ Next visit: _____

Diagnosed vision problem? Y N If so, what? _____

Eye treatment(s) ___glasses ___meds ___surgery ___patching ___none ___other: _____

Other diagnosed medical condition(s): _____

Current medications: _____

Note: It is unnecessary to screen a child with a diagnosed visual impairment or a child followed by an eye doctor who has been seen within the last 12 months, **as documented by a vision exam report.**

_____ CHECK HERE IF CHILD HAS A DIAGNOSED VISUAL IMPAIRMENT.

_____ Check here if child's medical vision exam report is attached to this form and no screening was conducted.

Skip down to "Results and Recommendations" section.

II. CHILD AND FAMILY HISTORY

CHILD history includes:

- | | |
|---|--|
| <input type="checkbox"/> Birthweight less than 3 lbs. | <input type="checkbox"/> Hydrocephaly/Shunt |
| <input type="checkbox"/> Cerebral palsy/High or low muscle tone | <input type="checkbox"/> Meningitis/Encephalitis |
| <input type="checkbox"/> Child infection at birth | <input type="checkbox"/> Neurological disorder/Seizures |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> Prolonged high fever |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Syndrome w/risk of serious vision concern |
| <input type="checkbox"/> FAMILY history <u>includes</u> a member (child's biological parent, grandparent, aunt/uncle and/or sibling) with a significant vision concern or a visual impairment not due to accident, injury, or aging (generally identified prior to adulthood). | |

CHILD AND FAMILY HISTORY RISK FACTORS ARE NOTED IN SECTION II: YES NO

III. EYE APPEARANCE

(With glasses? Y N N/A)

(Check off & indicate "O" for observed by screener or "P" for parent/guardian report)

Frequent or persistent presence of:

- | | |
|---|--|
| <input type="checkbox"/> Blank/"far away" look to eyes | <input type="checkbox"/> Red, swollen or encrusted eyelids |
| <input type="checkbox"/> Cloudy or "milky" appearance of eyes | <input type="checkbox"/> Squinting/closing/excessive blinking of eyes |
| <input type="checkbox"/> Droopy eyelid(s) | <input type="checkbox"/> Turning in/out/up/down of one or both eyes (2m) |
| <input type="checkbox"/> Jerky, "wiggling" eyes | <input type="checkbox"/> Unequal/unusual size/shape of eyes/pupils |
| <input type="checkbox"/> Random/"roving" eye movements (2m) | <input type="checkbox"/> Watery, red or irritated eyes |

EYE APPEARANCE CONCERNS ARE NOTED IN SECTION III: YES NO

IV. VISION CONCERN BEHAVIORS

(With glasses? Y N N/A)

(Check off & indicate "O" for observed by screener or "P" for parent/guardian report)

Child consistently:

- | | |
|--|--|
| <input type="checkbox"/> Covers/closes one eye when looking | <input type="checkbox"/> Rubs eye(s) |
| <input type="checkbox"/> Fails to look at/point to pictures in a book (1/2y) | <input type="checkbox"/> Seems unaware of distant objects (6m) |
| <input type="checkbox"/> Fails to notice objects above/below head (3m) | <input type="checkbox"/> Seems unaware of self in mirror (6m) |
| <input type="checkbox"/> Fails to visually follow moving objects (6m) | <input type="checkbox"/> Squints/closes eyes/cries/turns away in bright light |
| <input type="checkbox"/> Holds objects/books close to eyes | <input type="checkbox"/> Stops & steps/crawls over changes in floor texture or color |
| <input type="checkbox"/> Lacks face regard/eye contact (1/3m) | <input type="checkbox"/> Tilts/turns head to look |
| <input type="checkbox"/> Notices objects on one side only (3m) | <input type="checkbox"/> Trips over/bumps into things in path |
| <input type="checkbox"/> Over or under reaches for objects (5m) | |

VISION CONCERN BEHAVIORS ARE NOTED IN SECTION IV: YES NO

V. INTERVIEW QUESTIONS

Answered by: ___Mother ___Father ___Grandparent ___Other: _____
(Relationship)

Child's primary caregiver? YES NO

1. What have you noticed about your child's vision within your daily routine?

2. At what things does your child like to look?

3. Do you have any/additional concerns about your child's vision at this time? Y N

If so, what? _____

VISION CONCERNS ARE NOTED IN SECTION V: YES NO

VI. ADDITIONAL VISION ASSESSMENTS

1. _____ Date: _____ By whom? _____ Results: _____

2. _____ Date: _____ By whom? _____ Results: _____

ADDITIONAL ASSESSMENTS REVEAL VISION CONCERNS IN SECTION VI: Y N N/A

VII. RESULTS AND RECOMMENDATIONS

Check one of the following and make indicated recommendation to parent or guardian:

___ NO SCREENING WAS COMPLETED: Child is being followed by an eye doctor and has a medical vision exam report attached to this form. **Send "Screening Results Letter" to parent/guardian, indicating that no screening was completed and why. Provide parent/guardian with "ABCs of 'Red Flag' Vision Problem Indicators" sheet.**

___ PASS: Responses to ALL sections of the screening were "NO". **Send "Screening Results Letter" to parent/guardian. Provide parent/guardian with "ABCs of 'Red Flag' Vision Problem Indicators sheet.**

___ PASS/MONITOR: A "YES" response was recorded for Section II (Child and Family History) ONLY. Responses to all other sections were "NO". **Send "Screening Results Letter" to parent/guardian. Give parent/guardian an "ABCs of 'Red Flag' Vision Problem Indicators" sheet. Re-screen child within ONE YEAR.**

___ REFER: A "YES" response was recorded for ANY or ALL of Sections III-VI. **Send "Screening Results Letter" & "Vision Exam Report Form" to parent/guardian. Recommend a referral for a full vision examination by an eye doctor now. Send copy of screening to child's primary care physician. Provide parent/guardian with an "ABCs of 'Red Flag' Vision Problem Indicators" sheet.**

Screeener: _____ Title: _____ Phone: _____

Primary care physician: _____ Date last seen: _____