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 __ other: _____ __ none

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:

__ Birthweight less than 3 lbs.
__ Cerebral palsy / High or low muscle tone
__ Child infection at birth
__ Head trauma
__ Hearing loss
__ Hydrocephaly / Shunt
__ Meningitis / Encephalitis
__ Neurological disorder / Seizures
__ Prolonged high fever
__ Syndrome w/risk of serious vision concern

__ FAMILY history includes 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 ageing** (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:

__ Blank/"far away" look to eyes
__ Cloudy or "milky" appearance of eyes
__ Droopy eyelid(s)
__ Jerky, "wiggling" eyes
__ Random/"roving" eye movements (2m)
__ Red, swollen or encrusted eyelids
__ Squinting/closing/excessive blinking of eyes
__ Turning in/out/up/down of one or both eyes (2m)
__ Unequal/unusual size/shape of eyes/pupils
__ 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:

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

VISION CONCERN BEHAVIORS ARE NOTED IN SECTION IV: YES NO

(continued on next page)

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.***

Screener: _____ Title: _____ Phone: _____

Primary care physician: _____ Date last seen: _____