TAKING A LOOK!

A *First* Step in Vision Assessment for Ohio's Infants and Toddlers

(Revised for Dissemination)

Vision Screening Checklist with Guidelines for Completion

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Introduction

Vision screening is an effort to facilitate the early diagnosis and corrective medical treatment of many vision problems in young (and developmentally young) children. Early treatment of children's vision concerns is vital to life-long visual functioning. Vision screening additionally serves as a tool for identifying infants and toddlers who may have (uncorrectable) visual impairments. Early identification allows young children who are visually impaired, and their families, to benefit from vision-related intervention services that prevent or minimize developmental delays commonly associated with visual impairment and blindness.

"Taking A Look!" is a *first* step in assessing vision and obtaining needed medical eye care for infants and toddlers. It was created by a committee of Ohio educators serving young children who are blind or visually impaired, in response to federal (Part C) vision screening requirements and state of Ohio vision screening mandates for all children entering Ohio's "Help Me Grow" system. "Help Me Grow" provides services for infants and toddlers who exhibit a variety of developmental concerns, and their families.

The primary objectives of "Taking A Look!" are: 1) to pinpoint "red flag" indicators of potential vision problems; 2) to facilitate referrals to medical eye care professionals for comprehensive eye examinations; and 3) to guide parents and early childhood professionals in observing young children to identify possible vision problems. The overall goal of "Taking A Look!" is to promote a more comprehensive effort to identify Ohio's infants and toddlers with vision problems and to obtain medical care and vision-related educational services for them in a timely manner.

This booklet includes a copy of the "Taking A Look!" checklist (pages 2-3) and detailed instructions for completing items included in its seven sections: Background Information; Child and Family History; Eye Appearance; Vision Concern Behaviors; Interview Questions; Additional Vision Assessments; and Results and Recommendations. It is intended to be used as: 1) a training guide for professionals attending workshops for learning to use the "Taking A Look!" checklist and 2) as a reference guide for staff completing the checklist with young children and their families. The screening process involves observing and gathering information about a child's vision by (and from) a variety of *trained* professionals (e.g., school nurses, teachers of children who are visually impaired, early intervention specialists, service coordinators, optometrists, and/or ophthalmologists), as well as family members of young children. The sections may be completed in any order.

V. INTERVIEW QUESTIONS

Answered by: ___ Mother ___ Father ___ Grandparent ____ Other: _____ (Relationship)

Child's primary caregiver? Yes No

1. What have <u>you</u> 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) <u>ONLY</u>. 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 <u>now</u>. 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: _____

12) Current Medications: Record any medications that child is currently taking, based on medical records and parent/guardian report.

13) "NOTE: It is unnecessary to screen a child with a diagnosed visual impairment (severe, uncorrectable visual condition) -or- a child followed by an eye doctor who has been seen within the last 12 months - AS DOCUMENTED BY A VISION EXAM REPORT." Attach a copy of the current (within last 12 months) vision exam report (obtained from the child's eye doctor) to the "Taking A Look!" checklist. No further assessment is necessary to document a child's vision status.

14) CHECK HERE IF CHILD HAS A DIAGNOSED VISUAL IMPAIRMENT. Check off in the blank to the left if the child has been diagnosed with a(n) (uncorrectable) visual impairment.

15) Check here if child's medical vision exam report is attached to this form and no screening was conducted: Check off in the blank to the left. Skip down to "Results and Recommendations" section and check off "NO SCREENING WAS COMPLETED" option. Send "Screening Results Letter" to parent/guardian, with "NO SCREENING WAS COMPLETED" option checked on letter.

10) Syndrome with risk of serious vision concern: Check if child has ever been diagnosed with a syndrome that has a high likelihood of including a vision concern or impairment. (Examples: Down syndrome (Trisomy 21), CHARGE association, DeMosier syndrome, Fetal alcohol syndrome, Marfan syndrome, Goldenhar syndrome, Trisomy 13, etc.) See Appendix A, on pages 18-19, for a more comprehensive list of examples.

11) Family history includes a member (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): Check if any of child's ***biological*** family members have had a vision problem that was NOT due to accident, injury, or ageing. Most common would be a family member who required a very **strong** glasses prescription as a **child** ("high myopia" or "high hyperopia"). Other examples include: amblyopia; strabismus; nystagmus; ptosis; color vision deficiency; and retinitis pigmentosa (RP).

12) "CHILD AND FAMILY HISTORY RISK FACTORS ARE NOTED IN SECTION II: YES NO": Circle "YES" if item(s) are checked in Section II. Circle "NO" if NO items are checked in this section.

7) Squinting/closing/excessive blinking of eyes: Check if child's eyes frequently squint when child is looking, if one or both eye(s) remain closed most of the time and/or if child's eyes blink excessively (frequently and/or very pronounced eye closure) when looking.

8) Turning in/out/up/down of one or both eyes: Check if child (BY TWO MONTHS OF AGE) has eyes that frequently/persistently do not seem to be lined up and looking together—e.g., one or both eyes turn in, out, up or down much of the time or, in particular, when child is tired. Medical records may note "esotropia", "exotropia", "esophoria" or "exophoria". Record "NA" if child is younger than 2 months of age.

9) Unequal/unusual size/shape of eyes/pupils: Check if eyes or pupils (black center part of eyes) are unequal in size or are, in any other way, unusual in size or shape. (Examples: pupil(s) are not completely round; one eye appears to be larger than the other; one pupil appears larger than the other, one eye missing, etc.) Medical records may note "microphthalmia" or "coloboma".

10) Watery, red, or irritated eyes: Check if parent reports child's eyes frequently appear red or irritated or that they water excessively (not just due to occasional colds or allergies)..

11) "EYE APPEARANCE CONCERNS ARE NOTED IN SECTION III: YES NO". Circle "YES" if item(s) are checked in this section. Circle "NO" if NO items are checked in this section.

4) Fails to visually follow moving objects: Check if child (BY ONE MONTH) makes no attempts to follow close, slowly moving objects, starting at child's eyes and moving to the sides. Check if child (BY THREE MONTHS) is not following a close, slowly moving object, from side to side in front of the child's body. Check if child (BY SIX MONTHS) is not easily and smoothly able to follow moving objects in all directions.

5) Holds objects close to eyes: Check if child consistently looks at objects or pictures from a distance of a few inches (or closer).

6) Lacks face regard/eye contact: Check and circle "face regard" if child (BY ONE MONTH) does not look toward a familiar person's face. Check and circle "eye contact" if child (BY THREE MONTHS) does not look at the eyes of a familiar adult, or makes only fleeting glances toward adult's eyes, during interactions. Record "NA" if child is younger than one month of age.

7) Notices objects on one side only: Check if child (BY THREE MONTHS) consistently notices the presence of food, toys, people, and other objects only on one side, but seems unaware of objects located on the other side. Child may also be observed consistently bumping into objects, walls, or people to one side only while walking. Record "NA" if child is under 3 months of age.

8) Over or under reaches: Check if child (BY FIVE MONTHS) consistently is unable to directly and precisely reach for and touch/bat/grasp a stationary object that he/she is looking at. Child may be observed reaching beyond, reaching just short of, or "fishing around" for a desired object before touching it. Record "NA" if child is younger than 5 months of age and/or is physically unable to reach out his/her arms.

9) Rubs eye(s): Check if child frequently rubs one or both eye(s). Record "NA" if child is physically unable to rub his/her eyes.

10) Seems unaware of distant objects: Check if child (BY SIX MONTHS) consistently seems unaware of people walking at a distance around a room, loses track of a ball or other object that rolls several feet away, and/or does not spot a stationary, familiar person or object from 5-10 feet away. Record "NA" if child is under 6 months of age.

Section V: INTERVIEW QUESTIONS

PURPOSE: This section is intended to elicit direct, open-ended feedback from a child's significant adult(s) about the child's daily visual functioning and adults' concerns.

DIRECTIONS: Interview (in person or by telephone) a parent or other adult who is with the child for significant periods of time. Use written prompts to elicit more detailed information, as needed. Record information in spaces provided.

1) Answered by: Check person who is providing answers to the questions in this section. Check "Other" and write in relationship of person to the child if needed.

2) Child's primary caregiver? Circle "YES" if the person is responsible for the majority of the child's care. Circle "NO" if not.

3) What have you noticed about your child's vision within your daily routine? Use the following questions, as needed, to prompt the person who is responding. It may be unnecessary to ask all of these questions.
   a) Does your child have/tolerate wearing glasses (if applicable)?
   b) Does your child seem to see better at certain times of the day (morning, evening, when not tired, etc.)?
   c) Does your child seem to see better in certain lighting conditions (daylight, nighttime, bright/dim lights, etc.)?
   d) How close does your child hold objects to see them?
   e) How close does your child sit to watch TV?
   f) Does your child turn his/her head to one side when looking?
   g) Does your child make eye contact with you during conversation or vocal play?
   h) Does your child seem sensitive to light?
   i) Does your child seem to notice changes in walking surfaces (e.g., sidewalk to grass; tile to carpeting) and can he/she manage them without difficulty?
   j) Does your child reach accurately for things (not over or under reaching)?

Section VI: ADDITIONAL VISION ASSESSMENTS

PURPOSE: This section is intended to report the results of additional vision screening procedures used to determine the child's level of vision.

DIRECTIONS: Additional assessments may be administered by the "Taking A Look!" screener (if trained to do so) OR by another trained professional (eye doctor; nurse, teacher of children who are visually impaired, etc.) and recorded in this section. Additional vision screening components may include:

a) Photoscreening, such as with an MTI photoscreener.
b) Preferential Looking Test (PLT), such as Teller Cards, Lea Gratings, and others;
c) "Cover" Test
d) "Red Reflex" Test

1) Record the date of the assessment, the name and title of the person who completed it, and the results ("Pass"/"Refer" and comments).

2) "ADDITIONAL ASSESSMENTS REVEAL CONCERNS IN SECTION VI: "Y N N/A":
Circle "Y" if additional assessments administered revealed concerns.
Circle "N" if additional assessments administered revealed no concerns.
Circle "N/A" if no additional assessments were conducted.

4) Check "REFER" if:
"YES" responses were recorded in ANY or ALL of Sections III through VI. Give or send parents/guardian a "Screening Results Letter", recommending that they contact their primary care physician for a referral to an eye doctor for a full vision examination. Attach a copy of the "Infant-Toddler Eye Examination Report" form to be taken to the eye doctor and returned after the examination is completed (See Sample Form in Appendix E on page 26.) Also give the parent a copy of the "ABCs of 'Red Flag' Vision Problem Indicators" sheet (Appendix D).

It would also be helpful to give the parent/guardian a list of ophthalmologists and optometrists, in the family's home area, who have experience in examining young children (if possible).

5) Screener: Record name of person completing the checklist.

6) Title: Record job title/position of person completing the checklist.

7) Phone: Record daytime telephone # of person completing checklist.

8) Primary care physician: Record name of child's primary care physician (main doctor who treats child). If none, please note "None". Send results of the screening to child's primary care physician.

9) Date Last Seen: Record date of child's last office visit to the primary care physician. If unknown, record "Unknown". Use your best estimate, based on family and medical record input.

Marfan Syndrome - dislocation of lens, high myopia, glaucoma, possible retinal detachment.

Pierre Robin Syndrome - glaucoma, retinal detachment, strabismus.

Shaken Baby Syndrome - cortical visual loss, cataracts, vitreal & retinal damage.

Sturge-Weber Syndrome - glaucoma.

Treacher Collins Syndrome - coloboma.

Trisomy 13 - microphthalmos, colobomas, retinal malformations, lens and corneal opacities, optic nerve hypoplasia.

Von Recklinghausen Syndrome (Neurofibromatosis) - ptosis, glaucoma, optic nerve lesions or tumors, strabismus, nystagmus.

Encephalitis - inflammation of the brain.

Esophoria - a tendency of one eye to turn inward when it is covered.

Esotropia ("crossed eyes") - turning inward of one eye while the other eye looks straight ahead.

Exophoria - a tendency of one eye to turn outward when it is covered.

Exotropia - turning outward of one eye while the other eye looks straight ahead.

"Fixes and Follows" - eyes are able to fixate on visual targets and follow them as they move.

Functional Vision Evaluation - evaluation of how a child uses the vision that he/she has; conducted by a ***trained*** visual impairment educator.

Glaucoma - group of diseases characterized by increased pressure inside the eye that causes permanent vision field loss if not treated.

Herpes - virus that may cause inflammation or ulcers in the eyes and may affect nerves related to visual functioning.

"HM" (Hand Motion) - ability to see a hand as it moves.

Hydrocephaly (or hydrocephalus)- when excess fluid collects inside the skull and creates pressure on the brain.

Hyperopia - see Refractive errors.

Iris - colored portion of the eye.

Keratoconus - degenerative corneal disease affecting vision, usually in both eyes.

"LP" (Light Perception)- ability to distinguish the presence or absence of light.

"LProj." (Light Projection) - ability to determine the *location* of a light source.

McDowell Vision Screening - commercially available vision screening instrument for young and developmentally young children; conducted by a ***trained*** professional.

Meningitis - bacterial disease that causes inflammation of a portion of the brain.

Microphthalmos (microphthalmus; microphthalmia) - small, underdeveloped eyeball(s).

Myopia - see Refractive errors.

"NLP" (No Light Perception) - inability to see light (no vision present).

Night blindness - reduced ability, or inability, to see in dim lighting conditions and at night.

Nystagmus - involuntary, rapid movement ("wiggling") of the eyes.

Ophthalmologist (M.D.) - a medical doctor who specializes in diagnosing and treating diseases and disorders of the eye and can perform surgeries to correct some eye problems.

TORCH infections - (toxoplasmosis; rubella; cytomegalovirus; herpes) Types of organisms that may cause intrauterine infections in pregnant women and may affect their unborn children's vision (common vision condition is optic atrophy).

Toxoplasmosis - infection that may affect lungs, liver, brain, and the retina of the eye.

"Tunnel vision" - loss of peripheral vision; some central vision remains.

Visually evoked response (VER) (or visually evoked potential (VEP)) - computerized recording of electrical activity in the vision portion of the brain that results from stimulating the retina (back of the eye) with light flashes; used to detect vision problems in the retina-to-brain nerve pathway; conducted by a ***trained*** eye care professional.

Visual impairment - an uncorrectable vision loss, such as **"legal blindness"** (visual acuity of 20/200 or less in the best eye with correction (glasses) OR a visual field of 20 degrees or less) or **"low vision"** (corrected visual acuities ranging from about 20/70 to 20/200). While it is generally not possible to measure precise numerical acuities for infants and toddlers, visual functioning levels can be estimated by medical eye care professionals to document a suspected visual impairment.

Appendix D:

ABCs OF "RED FLAG" VISION PROBLEM INDICATORS: INFANTS & TODDLERS

(Adapted from "Signs of Possible Eye Trouble in Children" From Prevent Blindness America)

Appearance

Turning in/out/up/down of one or both eyes (after about 2 months of age).
Crusty, swollen or red eyelids.
Watery, red or irritated eyes.
Eyes that "wiggle" or are in constant random, roving motion.
Droopy eyelid(s).
Pupils of different sizes/shapes or that react to light differently.
Eyes that are of different sizes.
Cloudy or "milky" appearance to eyes.
Excessive squinting, closing or blinking of eyes when looking.
Blank, far-away look to eyes.

Behavior

Covers/closes one eye when looking.
Lack of/reduced eye contact (after about 3 months of age).
Tilts or turns head to look.
Holds books/objects very close to see.
Frowns or squints to see distant objects.
Rubs eyes frequently.
Over or under reaches for objects (after about 5 months of age).
Stumbles or bumps into things and appears awkward.
Stops and steps/crawls over changes in floor texture or color, when no step is there.
Excessive squinting, turning away, or closing eyes to the presence of light.

Complaints

Feeling dizzy or sick to stomach.
Headaches, usually after looking closely at something.
Itching or burning of eye(s).

ACKNOWLEDGMENTS

The "Taking A Look!" vision screening checklist for infants and toddlers was developed by the following committee members:

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"Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has."
Margaret Mead

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This checklist was adapted from portions of the following instruments and sources: TX Early Childhood Intervention Vision Screening (1998); Baby Watch Early Intervention Vision Screening, Vision Associates (1996); CO Vision Screening for Infants & Toddlers (1999); WA Screening for Vision and Hearing Concerns in Infants and Toddlers (2001); AK Vision Screening for Young Children (2001); CA Dept. of Ed. "First Look" (1998); Cuyahoga Co. Bd. of MR/DD Indicators of Vision Concerns Checklist (2001); Ski Hi Developmental Sequence of Functional Visual Abilities: Birth to Three Years (1998); SC School f/t Deaf & Blind, Effective Practices in Early Intervention: Functional Vision Screening Questions for the Family (no date); OH Vision Screening Guidelines (no date).

Date:

Dear _____,

Thank you for letting us screen your child's vision today. Vision is a very important part of your child's healthy growth, beginning at birth. Vision screening helps us to identify *possible* vision concerns. It does not replace an examination by an eye doctor.

If a possible concern is identified during the screening, an eye doctor can confirm (or rule out) the presence of a medical vision problem. Because some eye conditions in infancy may not be easily observed through a screening process, eye doctors are now recommending that parents take their children in for a ***full medical vision examination*** during their preschool years.

The result of your child's screening today is checked below:

____ NO SCREENING WAS COMPLETED: Your child is already being seen by an eye doctor, so a screening was not conducted.

____ PASS: No vision concerns were noted today.

____ PASS/ MONITOR: No vision concerns were noted today. ***However, your child may be at a higher than average risk for developing vision concerns, due to his/her health history and/or family history of vision concerns. Please watch carefully for any future concerns. Your child will be re-screened within a year.***

____ REFER : Possible vision concerns were noted today. ***An examination by an eye doctor is strongly recommended now. Please take this letter to your primary care doctor for a referral.***

When you see an eye doctor, please have the attached "Eye Examination Report" form filled out. Return this report form to us as soon as possible. We will help you to find an eye doctor if needed.

Enclosed is an "ABCs of 'Red Flag' Vision Problem Indicators" sheet to help you as you observe the way your child uses his/her vision. If, at any time, you notice a change in your child's vision or have additional questions, please contact your child's doctor or call:

_____ at _____

Service Coordinator/Vision Screener Telephone Number

Thank you.

ABCs OF "RED FLAG" VISION PROBLEM INDICATORS: INFANTS & TODDLERS

(Adapted from "Signs of Possible Eye Trouble in Children" From Prevent Blindness America)

Appearance

Turning in/out/up/down of one or both eyes (after about 2 months of age).
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Droopy eyelid(s).
Pupils of different sizes/shapes or that react to light differently.
Eyes that are of different sizes.
Cloudy or "milky" appearance to eyes.
Excessive squinting, closing or blinking of eyes when looking.
Blank, far-away look to eyes.

Behavior

Covers/closes one eye when looking.
Lack of/reduced eye contact (after about 3 months of age).
Tilts or turns head to look.
Holds books/objects very close to see.
Frowns or squints to see distant objects.
Rubs eyes frequently.
Over or under reaches for objects (after about 5 months of age).
Stumbles or bumps into things and appears awkward.
Stops and steps/crawls over changes in floor texture or color, when no step is there.
Excessive squinting, turning away, or closing eyes to the presence of light.

Complaints

Feeling dizzy or sick to stomach.
Headaches, usually after looking closely at something.
Itching or burning of eye(s).

INFANT/TODDLER EYE EXAMINATION REPORT FORM

Child's Name: _____ D.O.B.: _____
District/County: _____ School/Program: _____
Vision Concerns/Diagnoses: _____
_____

Is this child **Visually Impaired?** _____ Yes _____ No _____ Do not know

Visual Acuities: *Please record whatever acuities are available. If numerical acuity data are not attainable, please indicate best estimates (e.g., NLP, LP, LProj., HM, Fixes & Follows, CSM, or "suspect significant vision problem", etc.).*

	Without Correction		With Correction	
	Distance	Near	Distance	Near
Right Eye	_____	_____	_____	_____
Left Eye	_____	_____	_____	_____
Both Eyes	_____	_____	_____	_____

Test(s) conducted: ___ PLT ___ HOTV ___Snellen ___ VER ___ Other: _____

Refractive Error: RE: _____ LE: _____

Eyes in Alignment? Yes No Comments: _____

Color Vision Normal? Yes No Comments: _____

Visual Fields Full? Yes No Comments: _____

Condition is: __Stable __Progressive __Fluctuating __Uncertain __Capable of Improving

Recommendations for Medical Care & Education: _____
_____

Visual Aids Prescribed/Recommended: _____
_____

Last Exam Date: _____ **When do you want to see this child again?** _____
Examiner Name & Title: _____
Address: _____
_____
Phone: _____ Fax: _____

Signature: _____ Date: _____

Please Return this Form to: Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____

Thank you.