SEE ABILITY

NHS

Special School Eye Care Service

EYE & VISION EXAMINATION RESULTS REPORT

The information in this form will help everyone to understand your child's eyesight, eye health, visual strengths and limitations.
Where one is needed, this form includes your child's glasses prescription.
A copy should be kept with your child's health records and support plan in school

Child's Full Name		**DOB**	
Date of this test			
Recommended date of next test			

Section 1
SUMMARY & ACTIONS

About Your Child's Eyes Summary

ACTIONS:

Are glasses needed? (see Section 2)	☐ Y	☐ N	
Is the child/young person eligible for certification as visually impaired?	☐ Y	☐ N	☐ Difficult to conclude
If Yes, what are next steps?			
Is any action from the child/young person's GP required?	☐ Y	☐ N	
If Yes, what are next steps?			
Does the child/young person need to be referred to another specialist	☐ Y	☐ N	
If Yes, what are next steps?			
Are modifications to classroom/schoolwork needed?	☐ Y	☐ N	☐ Difficult to conclude
Further information:			
Should the ECHP include information about vision needs?	☐ Y	☐ N	☐ Difficult to conclude
Further information:			

Section 2
GLASSES

We tested to see if glasses are needed

New/updated Glasses are needed?	☐ Y ☐ N
There is a problem with focussing accuracy	☐ Y ☐ N ☐ Difficult to assess today
Further information:	

GLASSES PRESCRIPTION

RIGHT	**Sph**	**Cyl**	**Axis**	**Prism**	**Base**		**Sph**	**Cyl**	**Axis**	**Prism**	**Base**	**LEFT**
						DIST						
						NEAR						

When and how should these glasses be used? (eg. distance vision, close work, etc)	

Unless you have requested otherwise, we will supply, fit and repair your child's glasses in school without charge. If you have any queries, please contact:

Eye Care Team contact:	

For information on how to help your child get used to wearing their glasses, please see the resources at the SeeAbility website here.

Section 3
RESULTS OF THE VISION TESTS WE DID TODAY

Visual acuity is how well a person sees black on white detail with glasses if needed.

Vision is how well a person sees black on white detail without glasses.

We were able to measure vision/visual acuity for looking at things:	
- in the distance	☐ Y ☐ N ☐ Difficult to assess today
- close up	☐ Y ☐ N ☐ Difficult to assess today
The vision results were:	

We have included examples of what your child should easily see More examples can be found at here.	☐ Y ☐ N

Binocular vision and eye movements – this is how well eyes work together

There is a problem with this	☐ Y ☐ N ☐ Difficult to assess today
Further information:	

Visual field – this is how well a person can see things to the side of their central vision

There is a problem with this	☐ Y ☐ N ☐ Difficult to assess today
Further information:	

Contrast sensitivity – this is how well objects are seen against similarly coloured backgrounds

There is a problem with this	☐ Y ☐ N ☐ Difficult to assess today
Further information:	

Evidence of Cerebral Visual Impairment / Visual Processing difficulties – this is when there are visual difficulties caused by problems interpreting visual information in the brain, rather than the eyes

Evidence of Visual Processing difficulties	☐ Y ☐ N ☐ Difficult to assess today
Further Information:	

Section 4
RESULTS OF THE EYE HEALTH CHECK

Findings from health checks of the inside and outside of the eyes	
Does the child need to be referred to another specialist	☐ Y ☐ N
If Yes, what are next steps?	
Nature of referral	

Section 5
OTHER EYE EXAMINATION DETAILS

Where did the test take place?	
Who was present?	
What was already known about the eyes and vision?	
Did anyone have any questions or concerns about the eyes and vision?	

Section 6
TECHNICAL DETAILS FOR OTHER HEALTH PROFESSIONALS

Vision/Visual Acuity and Test Used	
Refractive Error	
Accommodative Function	
OMB and Motility/Eye Movement Control	
Contrast Sensitivity	
Visual Fields	
Eye Health Exam	
Visual processing	
Other findings	

Section 7
EYE CARE TEAM ASSESSORS

Name of Optometrist (Eye Test)	
Name of Dispensing Optician (Glasses)	
Email	
Telephone	

This Report has been distributed to: (check as appropriate/add other names as appropriate)			
☐	**Parent/Carer**	**Date Sent**	
☐	**School**	**Date Sent**	
☐	**Class Teacher/TA**	**Date Sent**	
☐	**QTVI**	**Date Sent**	
☐	**QTMSI**	**Date Sent**	
☐	**SaLT**	**Date Sent**	
☐	**Occupational Therapist**	**Date Sent**	
☐	**Physiotherapist**	**Date Sent**	
☐	**Nursing Team**	**Date Sent**	
☐	**Paediatrician**	**Date Sent**	
☐	**GP**	**Date Sent**	
☐	**Other: _____**	**Date Sent**	
☐	**Other: _____**	**Date Sent**	
☐	**Other: _____**	**Date Sent**	
☐	**Other: _____**	**Date Sent**	
☐	**Other: _____**	**Date Sent**	

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Report developed in partnership with SeeAbility and Ulster University