Iowa KidSight Vision-Screening
A JOINT PROJECT OF THE LIONS CLUBS OF IOWA AND
THE UNIVERSITY OF IOWA HOSPITALS & CLINICS
DEPARTMENT OF OPHTHALMOLOGY AND VISUAL SCIENCES

Evaluation Sheet

Child's Name _____________________________________  Date of Birth ______________________

Date of Vision Screening ________________________ City of Screening ______________________

Session Number _______________________________

Signature of parent/guardian authorizing release of this follow-up information:
______________________________________________________ Date _______________________

To be completed by Ophthalmologist/Optometrist: This patient has been referred to you after failing
a vision screening with Iowa KidSight. Please complete this form and fax it to (319) 467-5091 or mail it
in the enclosed envelope to Iowa KidSight, UIHC, Department of Ophthalmology and Visual Sciences,
2431 Coral Court #5, Coralville, IA 52241. This Evaluation Sheet is a critical part of finalizing the
screening process as it provides validation that the child was examined and validates the effectiveness
of this screening program. If you have questions, please call 319-467-5090.

1. Date of Exam: ______________________________

2. Reporting MD/OD (please print):
   Name:___________________________________________________________________________
   Address:________________________________________________________________________
   Phone:______________________________  Fax:____________________________________

   OS: __________
       a) CSM
       b) Fix and Follow
       c) Pictures (Snellen Equivalent)
       d) HOTV
       e) E-Game
       f) Other – Please Elaborate

4. Ocular Motility:
   Ortho: __________________  Method of Assessing Alignment (circle all that apply)
   Strabismus: ______________ b) Cross-Cover Testing
               a) Penlight
               c) Other – Please Elaborate

5. A Cycloplegic Refraction is recommended:
   Cyclogyl 1% ________________  Other ________________

   Refraction: OD ________ + ________ x ________ or OD ________ - ________ x ________
   ______________________________
   OS ________ + ________ x ________ or OS ________ - ________ x ________

6. Other Exam Notes _______________________________________________________________
   Anisocoria ________________  Ptosis __________________

7. Diagnosis:
   Amblyopia: Yes No
   Type: Strabismus ________ Anisometropia ________ Media Opacity ________ Other________

8. Treatment:
   None: ________ Glasses: ________ Other (please specify) _________________________________

9. Follow-up:
   None: ________ Other (include date) ___________________________________________________

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