UIC

PEDIATRIC OPHTHALMOLOGIC REPORT

DIVISION OF SPECIALIZED CARE FOR CHILDREN

Child's Name _____ DSCC# _____

Birthdate _____

Report of visit(s) of _____
Date(s)

Eye Examination _____

_____

Acuity Assessment:

Distance			
Uncorrected Visual Acuity		Best Corrected Visual Acuity	
Right	Left	Right	Left

Visual Field 1	
Right	Left

Ocularmotor Assessment _____

Diagnosis and ICD-9 Code _____

How is child impaired? _____

Comments _____

_____

Please check if appropriate:

☐ Treatment Recommended
- ☐ Medical
- ☐ Surgical
- ☐ Optometric ☐ glasses ☐ contact lenses
- ☐ Other _____

☐ Treatment not recommended _____

_____

☐ Visual field restriction _____

☐ Re-examination advised _____
- ☐ Six months
- ☐ Twelve months
- ☐ Other

_____
Approved Specialist Signature

_____
Address

Clear Form