Eye Exam Report for Individualized Education Program (IEP)

Instructions after doctor completes this form:
1)Retain a copy in the patient file
2)Fax to school – attention principal (or send copy via US mail to school mailing address)
3)Fax to 614-781-6521
** Doctor: Please note NA (not applicable) beside any item below that is not included in your routine examination.*

Name of student _____ **DOB** _____

Grade_____ **School** _____

Parent Name _____ **Date of exam** _____

Objective Findings

A. Visual Acuity

	At Distance		At Near	
Without Rx:	(R) 20/_____	(L) 20/_____	(R) 20/_____	(L) 20/_____
With old Rx:	(R) 20/_____	(L) 20/_____	(R) 20/_____	(L) 20/_____
With new Rx:	(R) 20/_____	(L) 20/_____	(R) 20/_____	(L) 20/_____

B. Binocular Status/Efficiency *Add* **Remarks** ***when Abnormal is marked.***

Near point of convergence

_____ Normal _____ Abnormal – Remarks:

Ocular motility (Eye movement accuracy: Ductions/versions)

_____ Normal _____ Abnormal – Remarks:

Ability to maintain focus at near (amplitude)

_____ Normal _____ Abnormal – Remarks:

Ability to change focus quickly and easily (facility)

_____ Normal _____ Abnormal – Remarks:

Binocular alignment distance (eye teaming at distance)

_____ Normal _____ Abnormal – Remarks:

Binocular alignment near (eye teaming at near)

_____ Normal _____ Abnormal – Remarks:

Binocular depth perception (stereopsis)

_____ Normal _____ Abnormal - Remarks

C. Color Perception

_____ Normal _____ Deficient _____

Diagnosis

Amblyopia diagnosis: (R) (L) (None)

Refractive diagnosis:

a) Myopia (nearsighted) (R) (L)
b) Hyperopia (farsighted) (R) (L)
c) Astigmatism (R) (L)
d) Emmetropia (No correction) (R) (L)

Ocular health diagnosis *Add* **Remarks** *when Abnormal is marked.*

External exam
_____ Normal _____Abnormal – Remarks:
Diagnosis

Fundus exam
_____ Normal _____Abnormal – Remarks:
Diagnosis

Binocular diagnosis
_____ Normal _____Abnormal – Remarks:
Diagnosis

Recommendations/Recommended Treatment

_____ *No treatment indicated.*
_____ *Present corrective lenses are satisfactory.*
_____ *New corrective lenses have been recommended.*
Remarks:
_____ *A program of amblyopia treatment has been implemented.*
_____ Eye drops (R) (L)
_____ Patching (R) (L)
_____ Other (explain)
Remarks:

_____ *Return to this office for further care on* _____ *(Date)*
_____ *Further evaluation for: (if yes, indicate what additional care is needed)*

Corrective lenses should be worn:

_____ *Constantly* _____ *Near only* _____ *Deskwork* _____ *Computer*
_____ *Classroom* _____ *Distance only* _____ *Sports*
Remarks:

Special recommendations for classroom interaction

Signature _____**(O.D.) (D.O.) (M.D.) Date**_____
Eye Care Provider _____
Address _____
Phone Number_____
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HIPAA Information Release Form

As parent or guardian of the student named above, I authorize the eye care provider listed to disclose (by mail or by facsimile) the results of the HB 95 Eye Exam Report for IEP to my child's school:

Name of School_____ Attention_____
Address_____ City_____ State _____ Zip___
Telephone_____Fax_____

The purpose of disclosing the Eye Exam Report is for use in connection with my child's Individualized Education Program (IEP).

I understand that authorized persons associated with my child's school (or school system) may have access to, and use of, the Eye Exam Report for the purpose described above.

I understand that while in possession of authorized school personnel, the Eye Exam Report is not covered by HIPAA. Instead, it is an "education record," whose privacy, use and disclosure is protected by the Family Educational Rights and Privacy Act ("FERPA").

I understand that my refusal to sign this Authorization will not affect my child's ability to obtain treatment from the eye care provider listed above.

I understand my right to inspect or copy information disclosed by this Authorization.

I understand I may revoke (cancel) this Authorization at any time. Revocation must be in writing. The eye care provider cannot be held responsible for having disclosed information in reliance of this Authorization before receiving a written revocation.

I release the eye care provider from legal liability for disclosing The Eye Exam Report (and Protected Health Information contained in it) as authorized by my signature below.

This Authorization will expire on:

Date_____, or

Event_____.

_____
Signature of Parent or Guardian

_____
Print Name

Date:_____