Vision Referral Letter

Child’s Name ________________________________Age/DOB _______________________

Dear Parent/Caregiver:

In keeping with the recommendations of the Minnesota Department of Health, your child was screened on _____/______/____ and re-screened on ____/____/____.

You are urged to take your child for a professional eye examination for the reason(s) checked below:

☐ Child has had complaints about his/her vision
☐ Child resisted having his/her eyes covered
☐ Was unable to complete screening or be rescreened
☐ Child/Family history of eye conditions
☐ External eye problems
☐ Possible eye muscle problems (noted by observation, corneal light reflex, binocular fix and follow, or unilateral uncover)
☐ Abnormal Retinal (Red Light) Reflex
☐ Possible stereopsis (depth perception) problems
☐ Plus lens screening (farsightedness)
☐ Your child was unable to read lines on the chart appropriate for age group OR the difference between vision in each eye was greater than one line (with) (without) corrective lenses
☐ Right 10 (20)/______ Left 10 (20)/______ or Right 10 (20)/______ Left 10(20)/______

Please have your eye care professional complete the form on the backside so that we can provide your child with the best care and support at school as possible.

Revised 10/2019
Dear Eye Care Provider,

Please complete and return this form to help provide continuity of care. Thank you.

School nurse name: ________________________________________________________

Phone: _________________________________ Fax: ________________________________
Address: ___________________________________________________________________
Email: ________________________________

Date of Exam: ________________

My findings include:

Right: _____/_____ Left: _____/_____ without corrective lenses

____Myopia ____Hyperopia ____Astigmatism

____Amblyopia ____Muscle Condition

Corrective lenses changed or prescribed: Best correction: R _____/_____ L _____/_____ 

☐ Treatment not required

☐ A visual handicap that may interfere with learning. Please describe and include any recommendations for accommodations: __________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

☐ External eye condition. Please describe:________________________________________

___________________________________________________________________________

___________________________________________________________________________

Child should return for follow up examination. Date: _____________________________

Provider Name: ______________________________________________________________

Clinic Name and Phone: _________________________________________________________