Childs Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A vision screening was done by a DHD #10 Technician and met the referral criteria requiring further evaluation by an eye care provider such as an Optometrist/Ophthalmologist.

DEAR EYE CARE PROVIDER:

This student has met the referral criteria indicated above. Please complete the area below and fax or mail this form to the health department information listed below.

Date of Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name (PRINT OR STAMP): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: ☐ Myopia ☐ Hyperopia ☐ Astigmatism

☐ Muscular ☐ Amblyopia ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Uncorrected R \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ L \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Corrected R \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ L \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent difficulty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment: ☐ Glasses ☐ Medical ☐ Muscular ☐ Surgical ☐ Other ☐ None

Follow-up Recommended: ☐ Week(s) ☐ Month(s) ☐ Years(s)

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for your time and cooperation.

Stephanie Perez, Hearing & Vision Technician

District Health Department #10

3986 N. Oceana Dr.

Hart, MI 49420

P: (231) 465-1943

F: (231) 873-4248