



InfantSEE™ Assessment Clinical Reporting Form

Visit Date: \_\_\_/\_\_\_/\_\_\_

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ months

Parent(s) Name: \_\_\_\_\_ Premature? Yes No

Gender: M F Ethnic Origin (from History Form): H C AA NA A PI

Reason for Visit: Requested InfantSEE™ Assessment Referred; reported problem: \_\_\_\_\_ Heard about program from: current patients print ads story in newspaper family/friends radio ads referred by pediatrician/MD TV website

Visual Acuity Fix & Follow Method: OD Y N OS Y N Resistance to Occlusion: OD OS None 10 Vertical Prism Test: Pass Fail OD OS OU Teller Richman Other

Ocular Motility Full Range of Motion (FROM) Motility Limitation: \_\_\_\_\_

Alignment / Binocular Potential Hirschberg: Aligned Misaligned Cover Test: Normal Alignment Strabismus: Phoria: Convergence Estimate: Normal Inadequate 10 Vertical Prism Test: Pass Fail Brückner Equal reflexes Whiter and Brighter: R L

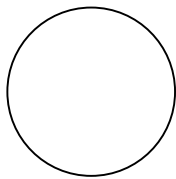
Refractive Status Manifest OD OS Additional OD Retinoscopy OS Mohindra Cycloplegic: Agent:

External/Anterior Segment Evaluation: Normal Problem Noted:

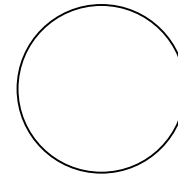
Visual Field Assessment: Full OU Full OD Full OS Problem Noted:

Pupil Evaluation: Normal Problem Noted:

Internal Assessment



CL Lens CL CL Vitreous CL Disc Vessels CL Macula CL + Foveal Reflex + Peripheral Retina



dilated non-dilated

Assessment: Visual Acuity Normal Problem: Ocular Motility Normal Problem: Binocularity Normal Problem: Strabismus: Esotropia Exotropia Refractive Status Normal Problem: Ocular Health Normal Problem:

Plan: No Concerns Recommended follow-up at Concerns Comments:

Optometrist Name (Please print) State Signature Date