Reset Form

InfantSEE™ Report to Pediatricians

Primary Health Care Provider Name: _____

Clinic and Address: _____

_____

_____

Infant Name: _____

DOB: _____/_____/_____

Parent(s) or Guardian(s): _____

InfantSEE™ Assessment Date: _____/_____/_____

InfantSEE™ Mission Statement: *InfantSEE™ is a public health program to ensure that professional eye and vision care becomes an integral part of infant wellness care, to improve a child's quality of life.*

Assessment Summary:

Developmental and Health History ◯ Normal ◯ Problem: _____

Family History ◯ Normal ◯ Problem: _____

Visual Acuity ◯ Normal ◯ Problem: _____

Ocular Motility ◯ Normal ◯ Problem: _____

Binocularity ◯ Normal ◯ Problem: _____

Strabismus: ◯ Esotropia ◯ Exotropia

Refractive Status ◯ Normal ◯ Problem: _____

Ocular Health ◯ Normal ◯ Problem: _____

Plans:

◯ No Concerns ◯ Concerns: _____

☐ Comments: _____

☐ Recommended follow-up at: _____

☐ Professional eye exams recommended every: ◯ 1 / ◯ 2 years

☐ Recommend ongoing wellness screenings with primary health care provider

_____

Optometrist Name (Please print) **Signature**