Vision Screening Referral Letter (3-5 Years)

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Dear Parent:

Your child recently received a vision screening. The screening showed that a thorough eye exam is needed. We suggest that you take your child to their health care provider or an optometrist/ophthalmologist as soon as possible. Please give this form to the provider to complete and return to our program

Early Learning staff _____

Child _____

Center and/or Site _____ Date _____

VISION SCREENING RESULTS

With Glasses ❒ Yes ❒ No

Right Eye:	20/
Left Eye:	20/
Both Eyes:	20/

Chart Used:
- ❒ Picture Cards
- ❒ HOTV
- ❒ Other

Date Screened:

Referral Due to:
- ❒ Observable signs and symptoms: _____
- ❒ Unscreenable
- ❒ Failed Acuity
- ❒ Parent/Teacher Request
- ❒ Hyperopia
- ❒ Strabismus

HEALTH CARE PROVIDER REPORT

ACUITY	Left	Right	Both
Without Lenses			
With Lenses			

	Yes	No
Glasses Prescribed	❒	❒
Special Accommodations Needed	❒	❒
Re-examination Needed	❒	❒

If yes, when? Date:_____

Remarks:

Date: Provider:

Please fill out this form and return it to parent, or address shown:

Center: _____
Attn: _____
Street: _____
City, State, Zip: _____