VISION REFERRAL Utah Department of Health in Accordance with UCA 53G-9-404	School Name: Address: City, State, Zip: Phone: Fax:
Date of Referral:	

Student Name:		DOB:	Grade:
Parent:	Phone:	Email:	
School Nurse:	Phone:	Email:	

Dear Parent/Guardian:
Schools routinely screen vision to identify students who have vision problems or might be at risk for vision problems. We refer students for an eye exam when they do not pass vision screening, or are at risk of a vision problem because of a medical or developmental reason. *Vision screening is not a substitute for a complete eye exam and vision evaluation by an eye doctor.*

You are receiving this document because your student (listed above)

- did not pass the vision screening, or
- should have an eye exam because of a medical or developmental risk for vision problem.

It is recommended your student receive a comprehensive eye exam with an eye doctor (an optometrist or an ophthalmologist). It is important to schedule this exam as soon as you can. Do not miss this appointment! If the eye doctor finds a vision problem, early treatment leads to the best possible results for your student's vision.

If you do not have insurance and need financial assistance in obtaining an eye exam and/or glasses for your student, please contact your school nurse to see if you qualify for our eye care program.

Reason(s) for this referral.

☐ Failed visual acuity (☐ distance / ☐ near)
☐ Readily recognized eye abnormality (i.e., strabismus, ptosis)
☐ Known diagnosis of neurodevelopmental disorder (i.e., hearing impairment, cognitive impairment, autism spectrum disorder, speech delay)
☐ Systemic disease known to have associated eye disorder (i.e., diabetes)
☐ Family history of vision problems
☐ Special Education referral/failed benchmark reading assessment
☐ Other (specify):_____

Please complete the Consent and Release of Information block below AND the top part of the back of this page. Take this paper with you to the eye exam and give the form to your eye doctor. Return the completed form to the school after the exam, or ask the eye doctor to send/fax exam results to the school.

CONSENT AND RELEASE OF INFORMATION

By my signature below, I authorize: (1) my student's eye doctor to send exam results to the school, (2) the school nurse and the eye doctor to discuss eye exam results, and (3) for the school nurse to notify the school of any specific vision problems and recommendations related to my student's specific vision needs. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain an eye exam for my student.

Parent/Guardian Signature:	Date:

COMPREHENSIVE EYE EXAM RESULTS Utah Department of Health in Accordance with UCA 53G-9-404	School Name: Address: City, State, Zip: Phone: Fax:
Date of Referral:	

Student Name:	DOB:	Grade:
Parent/Guardian:	Phone:	Email:
School Nurse:	Phone:	Email:

EXAM RESULTS FROM EYE CARE PROVIDER (optometrist or ophthalmologist):

The above named student is being referred for a comprehensive eye exam based on a recent school screening.

Please complete the section below and return form to the school (address/fax listed above).

Date of eye examination:
Check if appropriate:

☐ No problem on exam

☐ Treatment recommended
- ☐ glasses or contact lenses
- ☐ other (specify):_____

Best visual acuity with correction: Right:_____ Left:_____

☐ Significant vision impairment exists, I recommend referral for a Functional Vision Assessment from a Teacher of the Visually Impaired, either through the LEA or the Utah Schools for the Deaf and Blind.

Additional notes or recommendations:

EYE CARE PROVIDER CONTACT INFORMATION:

Provider Name:	Date of exam:
Provider Signature	☐ Ophthalmologist ☐ Optometrist

Address:	City:	Zip: