DEPARTMENT OF HEALTH

# Vision Referral Letter

Child's Name: _____ Age/DOB: _____

Dear Parent/Caregiver:

In keeping with the recommendations of the Minnesota Department of Health, your child was screened on _____/_____/____ and re-screened on _____/_____/____.

You are urged to take your child for a professional eye examination for the reason(s) checked below:

- ☐ Your child has had complaints about his/her vision
- ☐ Child/Family history of eye conditions
- ☐ External eye problems
- ☐ Possible eye muscle problems (noted by observation, corneal light reflex, binocular fix and follow, or unilateral uncover)
- ☐ Abnormal Retinal (Red Light) Reflex
- ☐ Possible stereopsis (depth perception) problems
- ☐ Plus lens screening
- ☐ Your child was unable to read lines on the chart appropriate for age group OR the difference between vision in each eye was greater than one line (with) (without) corrective lenses
- ☐ Right Eye 10/_____ (20/_____) Left Eye 10/_____ (20/_____)

Please have your eye care professional complete the form on the backside so that we can provide your child with the best care and support at school as possible.

**Dear Eye Care Provider, please complete this form.**

At your earliest convenience return to or have parent return to:

School nurse: Name _____

Phone _____Fax_____

Address_____

_____

Email_____

**Provider comments:**

I have examined_____

DOB _____on_____/_____/_____

My findings are:

Right: 10/_____ (20/_____) Left: 10/_____ (20/_____) without corrective lenses

- ☐ Insufficient to require treatment
- ▪ Muscular Condition:
- ☐ Fully correctible myopia
- ☐ Partially correctible hyperopia
- ☐ Not correctible astigmatism
- ☐ Corrective lenses prescribed
- ☐ Suppression
- ☐ Fusion condition
- ☐ Change in corrective lens
- ☐ External eye condition
- ▪ Best correction:
- ☐ R _____/_____
- ☐ L _____/_____
- ☐ No significant visual handicap to interfere with learning
- ☐ A visual handicap that may interfere with learning

Child should return for follow up examination on _____

Recommendations including any accommodations the school should make for the student

_____

_____

Provider Signature_____

Minnesota Department of Health
Child and Teen Checkups
651-201-3650
health.childteencheckups@state.mn.us
www.health.state.mn.us

01/2022

*To obtain this information in a different format, call: 651-201-3650.*