

Vision referral form

Utah Department of Health and Human Services in accordance with UCA 53G-9-404

Student name:	Date of birth:	Grade:
School name:	Address:	
Phone:	Fax:	
Parent/guardian name:	Parent phone/email:	
School contact:	Phone/email:	

Date of referral: _____

School vision screening results: A screening is not a substitute for a complete eye exam and vision evaluation by an eye doctor

Screening component tested	Pass	Refer	Not tested	Screening values or notes
Distance visual acuity	☐	☐	☐	Uncorrected: Right eye: 20/____ Left eye: 20/____
Two-line acuity difference	☐	☐	☐	Refer if difference is ≥ 2 lines between eyes (e.g. 20/20 vs 20/32)
Near visual acuity	☐	☐	☐	Uncorrected: Right eye: 20/____ Left eye: 20/____
Tracking	☐	☐	☐	☐ Smooth and consistent ☐ Jerky / uneven movement
Convergence	☐	☐	☐	☐ Normal alignment ☐ Breaks focus ≥ 4 inches from nose
Color vision	☐	☐	☐	Informational screening for classroom adjustments only

*Utah distance thresholds: 3 years old (20/50) | 4 years old (20/40) | 5 years and older (20/32)

Reason(s) for this referral:

- ☐ Did not pass visual acuity (distance /near)
- ☐ Convergence, tracking or readily recognized eye abnormality (such as strabismus, ptosis)
- ☐ Known diagnosis of neurodevelopmental disorder (such as hearing impairment, cognitive impairment, autism spectrum disorder, speech delay)
- ☐ Systemic disease known to have an associated eye disorder (such as diabetes)
- ☐ Family history of vision problems
- ☐ Special education referral / below benchmark reading assessment
- ☐ Other (specify): _____

Consent and release of information authorization: By my signature below, I authorize: (1) my student's eye care professional to send exam results to the school, (2) the designated vision point-person (DVPP) and the eye care professional to discuss eye exam results, and (3) for the designated vision point-person 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

To be completed by the eye care professional in accordance with UCA 53G-9-404

Student name:	Date of birth:	Grade:
Parent/guardian:	Phone/email:	
Eye care professional date of exam:	Clinic name:	

1. Visual acuity results

- Distance acuity *WITHOUT* correction: Right eye: 20/____ Left eye: 20/____
- Distance acuity *WITH* correction: Right eye: 20/____ Left eye: 20/____
- Near acuity *WITHOUT* correction: Right eye: 20/____ Left eye: 20/____
- Near acuity *WITH* correction: Right eye: 20/____ Left eye: 20/____

2. Binocular vision and ocular health

- Convergence: ☐ passed / normal ☐ concern noted ☐ not tested
- Ocular tracking / motility: ☐ passed / normal ☐ concern noted ☐ not tested
- Internal/external eye health: ☐ passed / normal ☐ concern noted: _____

3. Diagnosis and treatment recommendations

- ☐ No functional vision or ocular health problems identified upon exam.
- ☐ Amblyopia diagnosed or suspected
- ☐ Treatment recommended: ☐ Glasses prescribed ☐ Contact lenses prescribed ☐ Patching therapy
- Other treatment / diagnosis (specify): _____

Corrective lens wear recommendations for school:

- ☐ Constant wear (To be worn at all times during the school day)
- ☐ Near work only (Reading, classroom writing, desk activities, computer/tablet use)
- ☐ Distance work only (Seeing the board, assemblies, athletic activities)
- ☐ Remove for physical education (PE) or sports (Safety or contact risk protection precautions)

4. School recommendations

- ☐ Preferential classroom seating (e.g., placement close to front instruction boards)
- ☐ Large print materials or high-contrast reading text surfaces
- ☐ Structured visual rest breaks during prolonged near-work or screen tasks
- ☐ Color vision adjustments required
- ☐ Significant vision impairment exists- I recommend referral for a functional vision assessment from a teacher of the visually impaired, either through the local education agency or the Utah Schools for the Deaf and Blind.

5. Additional notes or recommendations: _____

Recommended return visit / Re-evaluation date: _____

Eye care professional contact information and signature

Provider name:		Credentials:
Clinic address:		
Clinic phone:	Clinic fax:	
Provider signature:		Date: