

# Screening Results Documentation Form

Form to be Completed by Healthcare Provider

Name: _____	School Year: _____
I authorize my child's physician to release this completed form to _____. Please fax to _____, Attention: _____ I understand that the requestor will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and the Health Privacy Act (including HIPPA).	
Parent/Guardian Signature _____	Date _____

Childs' Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Pure Tone Hearing Screening Results

	1000	2000	4000	Observation/Comments:
R	Pass _____ (20 dB)	Pass _____ (20 dB)	Pass _____ (20 dB)	
	Non Pass _____	Non Pass _____	Not Pass _____	
L	Pass _____ (20 dB)	Pass _____ (20 dB)	Pass _____ (20 dB)	
	Non Pass _____	Non Pass _____	Not Pass _____	

### EVALUATION RESULTS:

Diagnosis: \_\_\_\_\_  
 Treatment Plan: \_\_\_\_\_  
 Comments: \_\_\_\_\_

### Vision Screening Results

Acuity Test:	Uncorrected:	Corrected:	Indicate Type by placing a "X"	Electronic Screener (circle one):	Observation/Comments:
R	Pass:	Pass:	_____ Lea 5 ft. _____ Lea 10 ft. _____ Eye Check _____ Sloan Chart 10 ft	Suresight/Retinomax/JVAS	
	Non Pass _____	Non Pass _____			
L	Pass:	Pass:	_____ Lea 5 ft. _____ Lea 10 ft. _____ Eye Check _____ Sloan Chart 10 ft	Suresight/Retinomax/JVAS	
	Non Pass _____	Non Pass _____			
Stereopsis	Pass	Fail	_____ Smile (PASS 2) _____ Random Dot E		
Color Vision (Male Only)	Pass	Non Pass	_____ Ishihara - 14 plate _____ Pseudoisochromatic color testing - 16 plate _____ Color Vision Testing Made Easy		

### EVALUATION RESULTS:

Diagnosis: \_\_\_\_\_  
 Treatment Plan: \_\_\_\_\_  
 Comments: \_\_\_\_\_

Signature of examining Healthcare Provider: _____	Date of exam: _____
Address: _____	
Phone: _____	