

Vision Screening Training

Child Health and Disability Prevention (CHDP) Program
State of California CMS/CHDP
Department of Health Care Services



Revised 7/8/2013



ELEMENTS OF VISION SCREENING



Clinical Observation Provided by the Medical Practitioner

At each well child the medical practitioner provides these elements of vision screening starting at the child's first well-child visit:

- Patient/family history
- Inspection of the external eye
- Ophthalmoscopic visualization of the red reflex and fundus
- Pupillary reaction to light and accommodation
- Cover-uncover test
- Hirschberg's test (corneal light reflex)



Vision Screening Provided by Other Medical Staff

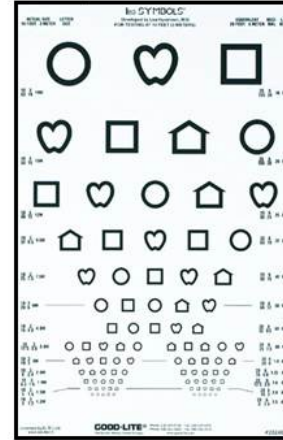
- Other medical staff provide vision acuity screening starting when the child is 3 years of age
- The child should be screened at EVERY well-child visit using a standardized eye chart
- Caregivers may be unaware of signs & symptoms of vision problems or consequences of delayed care

Eye Charts – Ages 3-5 years

HOTV Chart



LEA Symbols Chart



Both of these charts meet guidelines for standardized charts by the American Association of Ped. Ophthalmology and Strabismus—including the spacing of the symbols, spacing between lines, legibility of all symbols and 20-foot equivalent measurements on the right side of the chart. Be aware: not all charts sold are “standardized.”

Eye Charts – Ages 6 years & Older

Sloan Chart

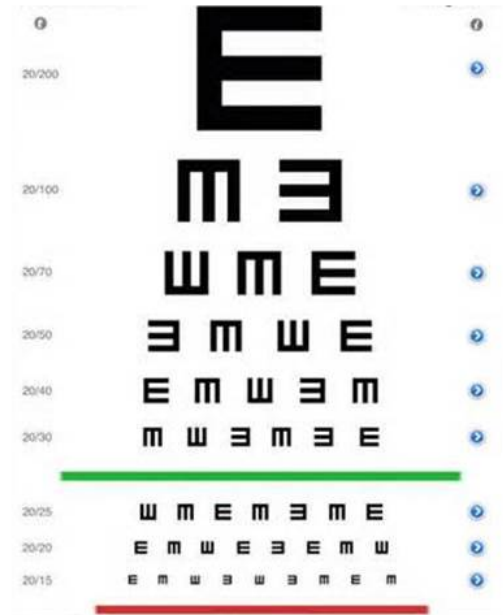
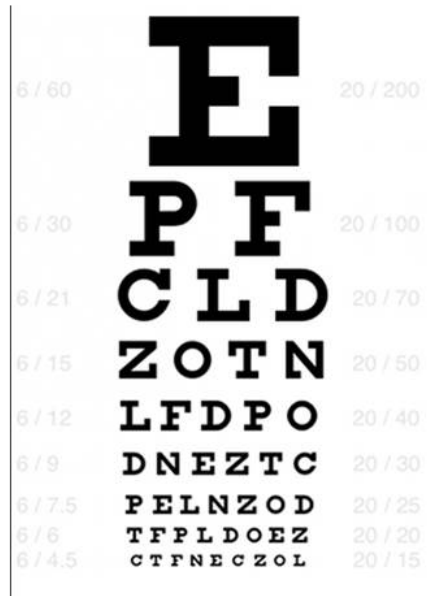


The Sloan Letters Chart is recommended since it meets national and international eye chart design guidelines.

The Snellen Chart is not recommended since it does not meet these guidelines for standardization.

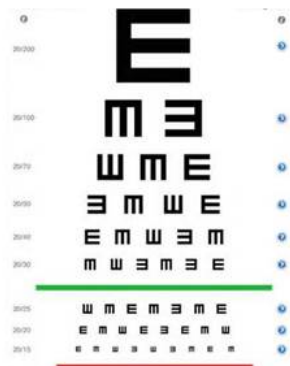
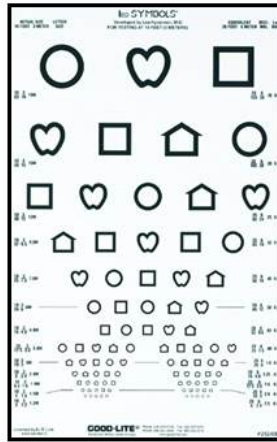
Although the American Association for Ped. Ophthalmology and Strabismus does not recommend the Snellen chart, they do comment that the Snellen chart is still better than no vision testing.

Snellen Charts: no longer recommended





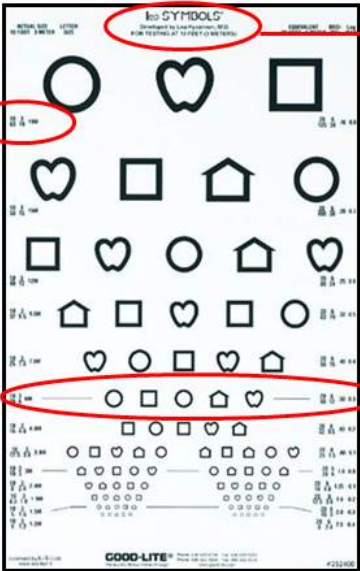
SPOT IT!



Properly Using the Eye Chart

Numbers on the **left** margin of the chart will indicate if it's a 10 or 20 ft chart

10/x
Or
20/x



At the top of the chart, it specifies at which distance the chart should be used – either 10 feet or 20 feet

This is the referral line – if this is the smallest line where the child can identify the majority of symbols, they should be referred to an eye specialist

Referral Line
Ages 3-5 years: **20/50**
Ages 6 years and older: **20/40**

Properly Using the Eye Chart



Type of chart and distance

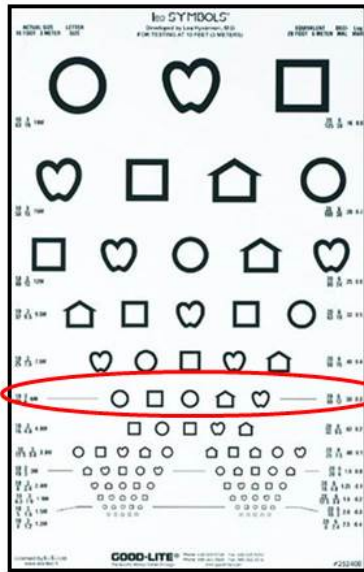
SLOAN LETTERS IN LogMAR SIZES FOR TESTING AT 10 FEET (3 METERS)

Sloan Chart (6 years +) ; the referral line is 20/40

20 40 R H S O N 20 40

20 40

On 10-foot charts, the 20-foot equivalent measurements are written on the right side







Occluder

- DO NOT use the child's hand to cover the eye
- Use non-disposable occluder and properly clean with alcohol after each use

OR

- Use disposable occluder, such as Dixie cup, tongue blades with back-to-back stickers, etc. and discard after each use

Occluder

- For preschool children, occluder glasses, such as those below, work very well
- Children who wear glasses should also be screened – they can be occluded with a non-disposable occluder or a post-it note attached to the glasses





Something to think about...

- PM 160 had documentation that states:
“Child screened without glasses”
- What does this mean? Is this correct?
Should the child be screened with glasses on?
- Farsightedness = Child uses glasses to read objects that are near



Screening Set-up

- Screen in a quiet, well-lit area, free from traffic and distractions
- The eye chart should be positioned so the referral line is at the eye level of the child
 - For preschool-age children, this is about 40 inches from the floor to the referral line
 - Ages 3-5 years, referral line is 20/50
 - Ages 6 years and older, referral line is 20/40

Screening Set-up

- The “**heel line**” should be marked on the floor – either 10 feet or 20 feet from the chart
 - Refer to the specific chart to know which distance to use (or if it’s not indicated—pay attention to the left side margins of the chart)





Observing the Child Before, During and After Screening

- Appearance of the eye
 - Examples: red or watery eyes; swelling around eyelids; slow or unequal pupils
- Behavior of the child
 - Examples: Rubs eyes frequently, shuts or covers one eye, squints eyes to see better, blinks excessively; the child may also thrust their head forward when trying to focus or move closer to objects to see
- Complaints from the child (Headaches or pain)
- Document any concerns so the provider can investigate further during the exam



Useful Tips for Promoting Cooperation During Screening

- Smile often. Be enthusiastic. Stay positive.
 - You are part of the environment. Make it fun and the child will be more cooperative. You have a great influence over the child's comfort and engagement.
- Give only one direction at a time.
- Give verbal praise after each answer.
- Promise a sticker at the end of the matching game. Encourage the child throughout the game.
- If able, screen the other eye of the child.



Other Tips for Promoting Cooperation During Screening – Matching Game

- Use the practice flash cards to condition the child to the LEA shapes
 - Lets the child get familiar with the game
 - Lets the screener learn what the child calls each shape
- Ask the child to call out the shape that matches the shape on your chart.



Matching Game

- If child is resistant to talk:
 - Option #1: Ask the child to point to the card that matches the shape on your eye chart.
 - Option #2: Place the individual flash cards on the floor in front of the child and ask the child to step on the shape that matches the shape on your eye chart.



Screening Procedure

- Select the eye chart based on the child's age
 - For ages 3-5, use the HOTV or LEA Symbols chart
 - For age 6 and older, use the Sloan Letters chart
- **The child should stand with their heels on the “heel line”**



Screening Procedure

- Screen the right eye first by placing the occluder over the left eye
 - The child **SHOULD NOT** hold the occluder – a teacher, aide or a member of the medical staff should hold the occluder over the child's eye
 - It is highly recommended that you use occluder glasses, especially with young children
- Start one line above the referral line
 - Ages 3-5 years, start at the 20/60 or 20/63 line
 - Ages 6 years and older, start at the 20/50 line



Screening Procedure

- To pass a line, the child must correctly identify one more than half of the figures on that line (3 out of 5 figures on most charts)
- If the child fails on any line, repeat the line in reverse order
- Continue to the smallest line of figures the child can pass and record the number on the PM 160 and the child's medical record
- Children have short attention spans. So if the child identifies 3 figures correctly move on to the next line

Pay attention....

- To how you point to the letters/symbols on the chart
- Best practices state placing your finger/pointing device directly under the letters/symbols causes the least amount of confusion for the child.
- Make sure you do not cover any part of the letters or symbols





DOCUMENTATION AND REFERRAL



What does 20/20 mean?

- The person can see from 20 feet what a person with normal vision can see from 20 feet
- 20/40 vision means the person can see from 20 feet what a person with normal vision would see from 40 feet



Documentation on the PM 160

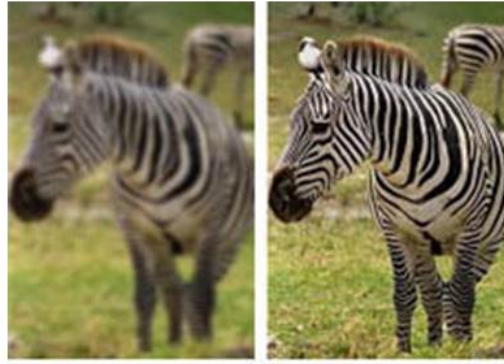
- Record the smallest line of figures the child can pass (refer to *Screening Procedure*), for example:
 - OD 20/20 (right eye)
 - OS 20/20 (left eye)
 - OU 20/20 (both eyes)
- If the child does not pass, record the failed screening on the PM 160 and the child's medical record



Failed Screening

- Visual acuity of 20/50 or worse in either eye for children age 3 through 5 years
- Visual acuity of 20/40 or worse in either eye for children age 6 years and older
- A two line difference or more in visual acuity between the eyes (e.g. 20/25 in one eye and 20/40 in the other eye)
 - Even if both eyes “pass” the screening, a two line difference or more between the eyes means they failed the screening, and should be referred to an eye specialist (this is one way to screen for amblyopia/lazy eye)

Amblyopia



Blurred View

Normal View

Fig. 1 Amblyopia occurs when one eye experiences a blurred view and the other a normal view, but the brain only processes the normal view

- This is what the zebra would look like through the eyes of a child with Amblyopia
- Over time the eye that “sees” the blurry image will be completely ignored by the brain

PM 160: Failed Vision Screening

FAILED VISION SCREENING												
CLAIM CONTROL NUMBER • FOR STATE USE ONLY										STAPLE HERE		
[Redacted]												
<div style="float: left; width: 10%; font-size: 8px;">DO NOT STAFF THIS AREA</div> <div style="float: right; width: 10%; font-size: 8px;">STAPLE HERE</div>												
PATIENT NAME (LAST)			PATIENT'S COUNTY OF RESIDENCE			MEDICAL RECORD NO.			I.A. CODE			
D O E			JANE			1 2 3 4 5 6 7 8 9 0			94 09446783 J			
BIRTHDATE		AGE	SEX	PATIENT'S COUNTY OF RESIDENCE		CO. CODE	TELEPHONE NUMBER		NEXT CHOP EXAM		<small>1. American Indian 2. Asian 3. Black 4. Hispanic 5. Other, Hispanic 6. Other 7. Other 8. No Race Indicated</small>	
Mo.	Day	Year		COUNTY			(310) 555-1212	Mo.	Day	Year		
02	25	011	F			19		07	01	10		
RESPONSIBLE PERSON (NAME)			(STREET)			(CITY)			(ZIP)			Ethnic Code
AMY DOE			1234 OAK STREET			TOWN			90022		6	
CHDP ASSESSMENT					PROBLEM SUSPECTED		DATE OF SERVICE		FOLLOW UP CODES			
Indicate outcome for each screening procedure					Enter For or Up Code in appropriate Column		Mo. Day Year		1. NO DX/RX INDICATED OR NOW UNDER CARE 2. QUESTIONABLE RESULT, RECHECK SCHEDULED 3. DX MADE AND RX STARTED 4. DX PERIODIC/REGULAR VISIT SCHEDULED 5. REFERRED TO ANOTHER EXAMINER FOR DX/RX 6. REFERRAL REFUSED			
					NEW	KNOWN	Mo.	Day	Year			
							07	01	10			
01 HISTORY and PHYSICAL EXAM							01	42.12		REFERRED TO: John Brown TELEPHONE NUMBER: (310) 555-4321		
02 DENTAL ASSESSMENT/REFERRAL										REFERRED TO: TELEPHONE NUMBER:		
03 NUTRITIONAL ASSESSMENT										COMMENTS/PROBLEMS IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA. 06 Failed vision (5) 20/50 OD 20/50 OS 20/50 OU Appointment scheduled with optometrist 07/26/09, 3:00 PM		
04 NUTRITIONAL GUIDANCE												
05 DEVELOPMENTAL ASSESSMENT												
06 SNELLEN OR EQUIVALENT						5	06	5.04				
07 AUDIOMETRIC							07	11.60				
08 HEMOGLOBIN OR HEMATOCRIT							08	3.01				
09 URINE DIPSTICK							09	2.87				
10 COMPLETE URINALYSIS							10					
12 TB MANTOUX							12					
CODE					OTHER TESTS		PLEASE REFER TO THE CHDP LIST OF TEST CODES		CODE			



Reasons to Refer

History or clinical observation

- Head tilting, squinting, nystagmus (repetitive, uncontrolled movements of the eye)
- Injury to or around the eye, or other clinical findings consistent with possible vision problem

Any abnormalities

- Abnormal alignment of the eyes, cataracts, eye muscle imbalances

All children who are not testable because of special medical problems

“High Risk” children

- Prematurity, family history of congenital cataracts, retinoblastoma, metabolic or genetic diseases
- significant developmental delay or neurologic difficulties, and systemic disease associated with eye abnormalities)



Importance of Referrals

- Younger children (under the age of 7 years) with vision problems should see an eye specialist as soon as possible – certain eye conditions can cause permanent vision loss if left untreated in young children
- Younger children tend to present with vision conditions that require a referral to an ophthalmologist more often than older children (e.g. Amblyopia, Strabismus, etc.)
- Optometrist (OD) vs Ophthalmologist (MD)

PM 160: Questionable Result

QUESTIONABLE RESULT									
CLAIM CONTROL NUMBER • FOR STATE USE ONLY									
STAPLE HERE									
<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">DO NOT STAPLE IN THIS AREA</div> <div style="border: 1px solid black; width: 200px; height: 20px;"></div> </div>									
PATIENT NAME (LAST)		(FIRST)		(INITIAL)		MEDICAL RECORD NO.		C.A. Code	
D O E		J A N E		A		1,2,3,4,5,6,7,8,9,0		05 94 09446782 J	
BIRTH DATE		AGE		SEX/M		PATIENT'S COUNTY OF RESIDENCE		CO. CODE	
Mo. 02 Day 25 Year 01		63		F		COUNTY		1,9	
RESPONSIBLE PERSON (NAME)		(STREET)		(APT./SPACE #)		(CITY)		(ZIP)	
AMY DOE		1234 OAK STREET				TOWN		010022	
CHDP ASSESSMENT Indicate outcome for each screening procedure		NO PROBLEMS SUSPECTED √A		REFUSED, CONTRA INDICATED, NOT RATED √B		PROBLEM SUSPECTED Date of CHDP Exam NEW KNOWN C D		DATE OF SERVICE Mo. Day Year 07 01 07	
						FEES		FOLLOW UP CODES	
01 HISTORY and PHYSICAL EXAM		✓				01 42.12		1. NO DX/RX INDICATED OR NOV UNDER CARE, 2. QRS SUSPICIOUS RESULT, RECHECK SCHEDULED, 3. DX MADE AND RX STARTED	
02 DENTAL ASSESSMENT/REFERRAL		✓						4. DX PENDING-RETURN VISIT SCHEDULED, 5. REFERRED TO ANOTHER EXAMINER FOR DX/RX, 6. REFERRAL REFUSED	
03 NUTRITIONAL ASSESSMENT		✓						REFERRED TO: TELEPHONE NUMBER	
04 PARTICIPATORY GUIDANCE		✓						REFERRED TO: TELEPHONE NUMBER	
05 DEVELOPMENTAL ASSESSMENT		✓						COMMENTS/PROBLEMS IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA 06 Questionable Result (2) 20150 0D 20140 0S 20150 04 Recheck scheduled 07/26/07, 3:00 PM	
06 SNELLEN OR EQUIVALENT				2		06 5.04			
07 AUDIOMETRIC		✓				07 11.60			
08 HEMOGLOBIN OR HEMATOCRIT		✓				08 3.01			
09 URINE DIPSTICK		✓				09 7.87			
10 COMPLETE URINALYSIS				✓		10			
12 TB MANTOUX				✓		12			
CODE OTHER TESTS		PLEASE REFER TO THE CHDP LIST OF TEST CODES		CODE OTHER TESTS					

PM 160: Incomplete Screening

INCOMPLETE VISION SCREENING

CLAIM CONTROL NUMBER * FOR STATE USE ONLY

DO NOT Staple This Area

STAPLE HERE

P 1 2 3 4 5 6 7 8 9 10 11 12	PARENT NAME (LAST) (FIRST) (INITIAL) S.MITH J.A.N.E. L.	MEDICAL RECORD NO. 9876543210	LA Code 09	94 09446785 J
	DATE (MM/Day/Year) AGE (Years) SEX/MARITAL STATUS 01/25/04 33 F	PARENT'S COUNTY OF RESIDENCE COUNTY	CO. CODE 19	TELEPHONE NUMBER (805) 555-1234
	RESPONSIBLE PERSON (NAME) AMY SMITH	(STREET) 1234 MAPLE LANE	(CITY) (ZIP) TOWN 90212	Ethnic Code 1. American Indian 2. Asian 3. Black 4. Hispanic/Latino 5. Other Amer./Hispanic 6. White 7. Other 8. Pacific Islander 6

CHDP ASSESSMENT Indicate outcome for each screening procedure	NO PROBLEM SUSPECTED √A	REFUSED, CORRECTED, NOT RELEASABLE √B	PERSONS SUSPECTED Enter Follow-Up Code		DATE OF SERVICE Mo Day Year	FEES	FOLLOW UP CODES 1. NO DX/RX INDICATED OR NOW UNDER CARE. 2. QUESTIONABLE RESULT, RECHECK SCHEDULED. 3. DX MADE AND RX STARTED.	4. DX PENDING/RETURN VISIT SCHEDULED. 5. REFERRED TO ANOTHER EXAMINER FOR DX/RX. 6. REFERRAL REFUSED.
			NEW	KNOWN				
01 HISTORY and PHYSICAL EXAM	<input checked="" type="checkbox"/>				01 39.00		REFERRED TO: TELEPHONE NUMBER	
02 DENTAL ASSESSMENT/REFERRAL	<input checked="" type="checkbox"/>						REFERRED TO: TELEPHONE NUMBER	
03 NUTRITIONAL ASSESSMENT	<input checked="" type="checkbox"/>						COMMENTS/PROBLEMS IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA 06 Child unable to follow directions recheck scheduled 11/05/07, 3:30 PM	
04 ANTI-PARASITIC CHEMOPROPHYLAXIS	<input checked="" type="checkbox"/>							
05 DEVELOPMENTAL ASSESSMENT	<input checked="" type="checkbox"/>							
06 SWELLEN OR EQUIVALENT		<input checked="" type="checkbox"/>			06			
07 AUDIOMETRIC	<input checked="" type="checkbox"/>				07 11.60			
08 HEMOGLOBIN OR HEMATOCRIT	<input checked="" type="checkbox"/>				08 3.01			
09 URINE DIPSTICK	<input checked="" type="checkbox"/>				09 2.87			
10 COMPLETE URINALYSIS			<input checked="" type="checkbox"/>		10			
12 TB MANTOUX			<input checked="" type="checkbox"/>		12			
CODE OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES					CODE OTHER TESTS		



Incomplete Screening

- If a child who is 3 years of age is unable to complete the screening, a second attempt should be made 4 to 6 months later
- If a child who is 4 years or older is unable to complete the screening, a second attempt should be made in 1 month
- Shyness, inattention or poor cooperation may be related to a vision problem

Pm 160: Vision Recheck

VISION SCREENING RECHECK		CLAIM CONTROL NUMBER - FOR STATE USE ONLY		STAPLE HERE	
PATIENT NAME: S.M.I.T.H. JANE		MEDICAL NUMBER: 94 09446788 J		DATE OF BIRTH: 01/25/84	
ADDRESS: 1234 MAPLE LANE		CITY: TOWN		STATE: VT	
PHONE: (802) 555-1234		FAX: (802) 555-1234		ZIP: 05601	
CHOP ASSESSMENT Multiple options for each screening procedure:		DATE OF SCREENING: 11/05/10 FEE: \$ 04		RESPONSE TO: SAMM JAMES RELATING NUMBER: (WS) 555-4821 VISITING NUMBER:	
01 HISTORY AND PHYSICAL EXAM 02 GENERAL ASSESSMENT/STETHOSCOPE 03 PULMONARY ASSESSMENT 04 ABNORMAL FINDINGS 05 DEVELOPMENTAL ASSESSMENT 06 SPECIALTY EQUIPMENT 07 STENOCHORIC 08 HEARING LOSS OR HEARING DEVICE 09 USUAL HEARING 10 COMPLETELY UNHEARING 11 TO BE MONITORED		1. Patient is Exposed to Passive Cigarettes: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 2. Tobacco Used by Patient: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3. Cigarettes Allowed/Refused for Tobacco Use Prevention Counseling: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		COMMENTS/PROBLEMS P.F. PROBLEMS/ISSUES BY VISITING CLERK THIS SCREENING IS FOR: vision recheck old failed vision (5) 20/40 wD 20/20 OS 20/20 OD patient to schedule appointment with optometrist	
SIGNATURE: Jane Smith DATE: 11/05/10		STATE OF VERMONT FOR A REAL-BUSINESS SCREENING PROGRAM VERMONT DEPARTMENT OF HEALTH SERVICES 100 SOUTH MAIN STREET MONTPELIER, VT 05601-1000		CONFIDENTIAL SCREENING/BILLING REPORT	

PM 160: Vision Recheck

CHDP ASSESSMENT Indicate outcome for each screening procedure	NO PROBLEM SUSPECTED √A	REFUSED, CONTRA-INDICATED, NOT ASSESSED √B	PROBLEM SUSPECTED Enter Problem Code Zoonoses/OT/MS		DATE OF SERVICE			FOLLOW UP CODES 1. NO DX/RX INDICATED OR RX/RX UNDER CARE 2. ONE STRUCTURE RESULT, RECHECK SCHEDULED 3. DX MADE AND RX STARTED 4. DX PENDING/RETURN VISIT SCHEDULED 5. REFERRED TO ANOTHER EXAMINER FOR DX/RX 6. REFERRAL REFUSED				
			NEW C	KNOWN D	Mo.	Day	Year					
01 HISTORY and PHYSICAL EXAM					01		11	05	07	FEES	REFERRED TO: Sam Jones	TELEPHONE NUMBER (005) 555-4321
02 DENTAL ASSESSMENT/REFERRAL											REFERRED TO:	TELEPHONE NUMBER
03 NUTRITIONAL ASSESSMENT											COMMENTS/PROBLEMS IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA Vision Recheck 06 Failed vision (5) 20/40 OD 20/20 OS 20/20 OU parent to schedule appointment with ophthalmologist	
04 LABORATORY CLEARANCE FROM THE REFERROR												
05 DEVELOPMENTAL ASSESSMENT												
06 SNELLEN OR EQUIVALENT				5	06	5.04						
07 AUDIOMETRIC					07							
08 HEMOGLOBIN OR HEMATOCRIT					08							
09 URINE DIPSTICK					09							
10 COMPLETE URINALYSIS					10							
12 TB MANTOUX					12							
code	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES				code	OTHER TESTS					

SERVICE LOCATION: Home, Address, Telephone Number Please include Area Code	PROVIDER NUMBER N P I N U M B E R	PLACE OF SERVICE 11	<input type="checkbox"/> Child in Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other
Your Facility / Provider Name	NOTE: WHO requires Hb, Wb, and Hemoglobin/Electrolytes		<input type="checkbox"/> PARTIAL SCREEN <input checked="" type="checkbox"/> SCREENING PROCEDURE RECHECK
Your Street Address	AS COMPANIES FORM PM 160 DATED		0 7 0 1 0 7
City, State, 9-digit Zip Code	PARENT SIGNATURE	DATE	IDENTIFICATION NUMBER
Your telephone Number	ELIGIBILITY	1 9 8 W 5 4 5 8 4 3 6 8 9 1	



Referrals

- Refer to appropriate specialty provider who accepts Medi-Cal
- For children with Temporary Full-scope Medi-Cal (through CHDP Gateway) – stress the importance of seeing the specialty provider prior to expiration of temporary Medi-Cal
- Pink copies of the PM 160 must be given to the parent/family for each visit. They can bring the pink copy to their eye appointment



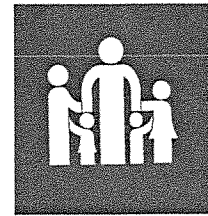
Follow-up

It is the responsibility of the referring clinic or provider to:

- Maintain a referral log to track the status of the referral
- Follow-up with the parent/guardian as needed

THANK YOU!





Vision Screening Training Evaluation Form

Training Date: _____

Address: -----

Note: On scale 1-4, 4 being the best, please rate the facilitator(s) on the following:

Please check the box to respond to the following training areas:

TRAINING FACILITATOR/ PROCTOR	Poor	Fair	Good	Excellent
Facilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TRAINING CONTENT	Strongly Disagree	Disagree	Agree	Strongly Agree
I was well informed about the objectives of this workshop	1	2	3	4
The training materials provided were useful	1	2	3	4
The contents were relevant	1	2	3	4

TRAINING RESULTS	Strongly Disagree	Disagree	Agree	Strongly Agree
The program met my expectations	1	2	3	4
I will be able to use what I learned in this training	1	2	3	4

Comments:

Completion of this evaluation is needed to receive a certificate of attendance.

Date : _____

Vision Screening Skills Check-Off

Pass <input type="checkbox"/> Fail <input type="checkbox"/>	1. Correctly identifies vision chart, heel line length, and heel placement.
Pass <input type="checkbox"/> Fail <input type="checkbox"/>	2. Places chart at child's eye level, identifies age appropriate referral line, and begins screening at 1 line above the referral line. <input type="checkbox"/> Age 3-5 : Referral line 20/50; Begin Screening 20/60 <input type="checkbox"/> Age 6+ : Referral Line 20/40; Begin Screening 20/50
Pass <input type="checkbox"/> Fail <input type="checkbox"/>	3. Systematically conducts screening, appropriate use of pointer.
Pass <input type="checkbox"/> Fail <input type="checkbox"/>	4. Correctly identifies criteria for "passing a line" and moves to the next line. <input type="checkbox"/> Child identifies 1 more than half figures 4a. If a child fails on any line, repeats the line in reverse order
Pass <input type="checkbox"/> Fail <input type="checkbox"/>	5. Correctly records the results for Right Eye and Left Eye.
Pass <input type="checkbox"/> Fail <input type="checkbox"/>	6. Appropriately identifies failed screening criteria. <input type="checkbox"/> Age 3-5 : Visual acuity 20/50 or worse in either eye <input type="checkbox"/> Age 6+ : Visual acuity 20/40 or worse in either eye <input type="checkbox"/> 2 line difference or more between the eyes, even if they "pass" both eyes
Pass <input type="checkbox"/> Fail <input type="checkbox"/>	7. Appropriately refers child who has failed screening.
Pass <input type="checkbox"/> Fail <input type="checkbox"/>	This participant has correctly demonstrated the vision screening skills as taught by this training.

 This will serve as your evidence of completion until your certificate arrives by email

Name: _____ Name of CHDP Staff: _____

Vision Screening Training Results	
<input type="checkbox"/> You have successfully passed the training	<input type="checkbox"/> You will need to re-take the training