

Firstname	Lastname	HAS ID _____
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Date	O Male O Female	DoB	Age (years) O Not sure
Event	Location	O Athlete O Unified partner	Sport
Delegation		SO Program	

History

Is this your first time through an SOLCIOE Screening?
 Yes No

When was your last eye exam?

- Less than 1 year
- 1-3 years
- More than 3 years
- Never
- Unknown

Do you wear corrective lenses (glasses or contacts)?

- Yes No
- Standard Rx Full time Near only
 - Far only Sport
 - Sports Rx Full time
 - Sport
 - Contact lenses Soft
 - RGP

Do you experience any of the following

- Difficulty seeing
 - Far
 - Near
- Headaches
- Sensitivity to light
- Double vision
 - Far
 - Near



Have you ever had an:

Injury Details

Surgery Details:

Infection Details:

Screening

Please check one

Current prescription

	<input type="radio"/> Without Rx	<input type="radio"/> With Rx	<input type="radio"/> With contact lenses		
	Sphere	Cylinder	Axis	ADD	PD
Right eye					/
Left eye					

Pass Not Pass **Visual acuity FAR** Unable to test **OD 20 / ____** Unable to test **OS 20 / ____**

 Do not pass if 20/40 or worse

Lea Other: Lea Other:

- Walk up
- Light projection
- Light perception
- No light perception
- Other

Pass Not Pass **Visual acuity NEAR** **OU 20 / ____**

 Unable to test Lea Other:

Do not pass if 20/40 or worse

Pass Not Pass **Cover test** Far

 Unable to test ortho phoria trope

- eso
- exo
- hyper
- range 02-99 ____

O Latent Nystagmus Constant Intermittent

range 02-99 ____

 Unable to test Near

ortho phoria trope

- eso
- exo
- hyper
- range 02-99 ____

Constant Intermittent

range 02-99 ____

Pass Not Pass **Color vision**

 Unable to test Trial 1 ____ / 9 If less than 8/9 Trial 2 ____ / 9

Do Not Pass if Trial 2 < 9

Pass Not Pass **Stereopsis**

 Unable to test ____ / 6

Do Not Pass if < 5/6 correct

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Autorefractation

	Sphere	Cylinder	Axis
<input type="checkbox"/> Unable to test OD			
<input type="checkbox"/> Unable to test OS			

Pass Not Pass **Eye Health**

Record all abnormalities and if referral required

	Right Eye	Left Eye
External	<input type="checkbox"/> Unable to test <input type="checkbox"/> Normal <input type="checkbox"/> Lid anomaly <input type="checkbox"/> Blepharitis <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Pterigium/pinguecula <input type="checkbox"/> Corneal anomaly <input type="checkbox"/> Ptosis Abnormality	<input type="checkbox"/> Unable to test <input type="checkbox"/> Normal <input type="checkbox"/> Lid anomaly <input type="checkbox"/> Blepharitis <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Pterigium/pinguecula <input type="checkbox"/> Corneal anomaly <input type="checkbox"/> Ptosis Abnormality

Pass Not Pass
Record all abnormalities and if referral required

	Right Eye	Left Eye
Internal	<input type="checkbox"/> Unable to test RE <input type="checkbox"/> Normal <input type="checkbox"/> Iris anomaly <input type="checkbox"/> Cataracts <input type="checkbox"/> Coloboma <input type="checkbox"/> Retinal anomaly <input type="checkbox"/> Optic nerve anomaly <input type="checkbox"/> Glaucoma suspect <input type="checkbox"/> Nystagmus Abnormality	<input type="checkbox"/> Unable to test LE <input type="checkbox"/> Normal <input type="checkbox"/> Iris anomaly <input type="checkbox"/> Cataracts <input type="checkbox"/> Coloboma <input type="checkbox"/> Retinal anomaly <input type="checkbox"/> Optic nerve anomaly <input type="checkbox"/> Glaucoma suspect <input type="checkbox"/> Nystagmus Abnormality

Pass Not Pass Unable to test
 Pass Not Pass Unable to test

	Pupils	IOP
	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Icare tonometry	Abnormality: <input type="checkbox"/> Noncontact tonometry
	OD	OS

Optional

	Retinoscopy	Refraction
Right eye	20/ ____	20/ ____
Left Eye	20/ ____	20/ ____
		Near Add 20/ ____

Recommendations

No new Rx
 No glasses recommended
 No change in glasses recommended

New Rx
 Full time Rx

	Sphere	Cylinder	Axis	VA Distance	VA Near (OU)	ADD
Right eye				20 / ____	20 / ____	
Left eye				20 / ____		
<input type="checkbox"/> Distance only						
Right eye				20 / ____		
Left eye				20 / ____		
<input type="checkbox"/> Close work only						
Right eye					20 / ____	
Left eye					20 / ____	
<input type="checkbox"/> Sports goggles						
<input type="radio"/> Plano						
<input type="radio"/> Rx						
Right eye				20 / ____	20 / ____	
Left eye				20 / ____		

Referral Reminded athlete that this is a screening and to get regular eye exams

Referral to:

<input type="checkbox"/> Optometrist	<input type="checkbox"/> Primary care physician
<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Other
<input type="checkbox"/> Neurologist	

Additional comments