



UNIVERSITY OF ILLINOIS AT CHICAGO

PEDIATRIC OPHTHALMOLOGIC REPORT

DIVISION OF SPECIALIZED CARE FOR CHILDREN

Child's Name _____ DSCC# _____

Birthdate _____

Report of visit(s) of _____ Date(s) _____

Eye Examination _____

Acuity Assessment:

Distance			
Uncorrected Visual Acuity		Best Corrected Visual Acuity	
Right	Left	Right	Left

Visual Field 1	
Right	Left

Ocularmotor Assessment _____

Diagnosis and ICD-9 Code _____

How is child impaired? _____

Comments _____

Please check if appropriate:

- Treatment Recommended
 - Medical
 - Surgical
 - Optometric glasses contact lenses
 - Other _____

Treatment not recommended _____

Visual field restriction _____

Re-examination advised _____

- Six months
- Twelve months
- Other

Approved Specialist Signature

Address