

Sample CHDP Vision Screening Referral Form

Child's first name: _____ Child's last name: _____

Date of exam: _____

Primary Care Provider Name: _____

Primary Care Provider Phone No.: _____

Primary Care Provider Address: _____

Reason for referral:

- | | | |
|---|--|--|
| <input type="checkbox"/> History | <input type="checkbox"/> Corneal light reflex | <input type="checkbox"/> Ophthalmoscopy |
| <input type="checkbox"/> External exam | <input type="checkbox"/> Cover test | <input type="checkbox"/> Visual acuity screening |
| <input type="checkbox"/> Red reflex testing | <input type="checkbox"/> Fix and follow response | <input type="checkbox"/> Instrument-based vision screening |
| <input type="checkbox"/> Pupil exam | | |

Explanation:

Referred to:

