InfantSEE Clinical Reporting Form
http://exam.infantsee.org

Date of Exam _____/ _____/ _____

Gender: □ M □ F  Date of Birth _____/ _____/ ______  Age (in Months): ____________________________

Patient City________________________________________ State _______  Zip __________

Birth History: Born Premature? □ Yes □ No  If yes: born at how many weeks premature_____________________

Delivery Complications: ____________________________________________________________

Ethnic Origin: □ Hispanic  □ Caucasian  □ African American  □ Native American  □ Asian  □ Other

Insurance: □ Yes □ No  If yes: □ Private □ CHIP □ Medicaid □ Other, specify________________________

How did you find out about InfantSEE?

□ Current Patient □ Radio □ Parenting Classes
□ Friend/Family □ Internet □ Other, specify __________________________
□ Mail □ Newspaper □ Primary Health Provider
□ TV

Yearly Household Income:

□ Less than $20,000  □ $20,000-$39,999  □ More than $100,000
□ $40,000-$59,999  □ $60,000-$79,999  □ $80,000-$99,999

Medical History
________________________________________________________________________________________
________________________________________________________________________________________

ASSESSMENT  (Use InfantSEE® Clinical Assessment Criteria)

Ocular Motility □ No Concern □ Concern □ Problem ____________________________

Binocularity □ No Concern □ Concern □ Problem ____________________________

Refractive Status □ No Concern □ Concern □ Problem ____________________________

Visual Acuity □ No Concern □ Concern □ Problem ____________________________

Ocular Health □ No Concern □ Problem ____________________________

Dilation □ Yes □ No

Plan □ No Concerns
□ Concerns and in need of follow up care in ______ months or ______ weeks

Referral to: ____________________________________________________________

Recommended follow-up: ____________ years of age

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<th>OD Name/AOA Number</th>
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If unable to enter online, mail to: 243 N. Lindbergh Blvd., St. Louis, MO  63141 or fax to: (314) 991-4101
For questions Call: (800) 365-2219, ext. 4286 or write to: infantsee@aoa.org
**Ocular Motility**
- □ No Concern – ability to look at the target, follow and maintain for a brief period or until something else captures the attention
- □ Concern – Reduced ability to gain visual attention in the primary position
- □ Problem - Any limitation of movement in the cardinal meridian

**Binocularity (Cover Test Data)**
- □ No Concern – stereo response on gross targets
- □ Concern – no response on stereo targets
- □ Problem – obvious or subtle strabismus

**Refractive Status**
1. **Hyperopia**
   - □ No Concern – Less than +3.50 - discuss risk, what to watch for, and usually seen at age 3
   - □ Concern – Between +3.50 and +5.00 - definite need to follow up within 6 to 12 months
   - □ Problem – Over +5.00 - establish patient in an optometric office

2. **Myopia**
   - □ No Concern - Less than -1.00 - discuss risk, what to watch for, and usually seen at age 3
   - □ Concern – Slightly over -1.00 definite need to follow up within 6 to 12 months
   - □ Problem – Well over -1.00 - establish patient in an optometric office

3. **Astigmatism**
   - □ No Concern – Less than 2.00 - discuss risk, what to watch for, and usually seen at age 3
   - □ Concern – 2.00 to 3.00 - Definite need to follow up within 6 to 12 months
   - □ Problem – 3.00 – over 3.00 - Establish patient in an optometric office

4. **Anisometropia**
   - □ No Concern – Less than 1.00 - discuss risk, what to watch for, and usually seen at age 3
   - □ Concern – Between 1.00 and 2.00 - definite need to follow up within 6 to 12 months
   - □ Problem – Over 2.00 - establish patient in an optometric office

**Visual Acuity / Looking Behavior**
- □ No Concern
- □ Concern – Reduced ability to look/fixate
- □ Problem – Fixation preference for one eye or Failed Visual Acuity test

**Ocular Health**
- □ No Concern
  - □ Problem – any noted anomaly