Station 1: Check In

First Name: _____ Last Name: _____ HAS ID: _____

Event Date: ____/____/_____ Date of Birth (mm/dd/yyyy): ____/____/_____ Age (years): _____

Event Location (City, State/Province or Country): _____ Delegation/SO Program: _____

Gender: ◯ Female ◯ Male ◯ Prefer not to answer Athlete Status: ◯ Athlete ◯ Unified partner ◯ Other

Sport: _____ Cell Phone: _____ Number is: ◯ Athlete's ◯ Parent's/Guardian's

Providing a phone number is optional. It will be used to send a text reminder if any follow-up is recommended after screening.

History

When was the last time you had an eye exam?

◯ Within the last month ◯ Within the past year ◯ Within the past 2 years ◯ 2 or more years ago
◯ I don't know ◯ Did not answer

In the past 12 months, have you experienced any of the following:

☐ Headaches ☐ Cloudy or blurry vision ☐ Sensitivity to light

☐ Difficulty seeing
◯ Distance ◯ Near ◯ Both

☐ Double vision
◯ Distance ◯ Near ◯ Both

◯ I don't know ◯ None of the above ◯ Did not answer

Have you ever been told by a doctor or other health worker that you have raised blood sugar or diabetes?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

Is your blood sugar level stable?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

Has your doctor ever told you have a thyroid disorder?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

Do you wear corrective lenses (glasses or contacts)?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

If yes, what do you wear?

◯ Glasses ◯ Contacts ◯ Both

When do you wear your glasses? (TV, reading, computer, phone, sports)

☐ Full time ☐ Part time ☐ Sport Goggles for Distance contact sports participation only

What do you wear your glasses for?

Full time: ☐ Multi-focal ☐ Distance ☐ Near
Part time: ☐ Multi-focal ☐ Distance ☐ Near

What type of contacts are worn?

☐ Distance ☐ Monovision ☐ Multi-Focal

Indicate how the athlete presents to the screening:

◯ With glasses ◯ With contact lenses ◯ Without corrective lenses (glasses or contacts)

Station 2: Lensometry

Screener's Name:

Current Prescription

	Sphere	Cylinder	Axis	Horizontal Prism	Base	Vertical Prism	Base	Add
Right Eye								
Left Eye								

Prismatic Evaluation

	Pupillary Distance	PD measured from eyewear	Ocular Center
Right Eye			
Left Eye			

Briefly describe, include prismatic effect if known, using formula [Prism (diopters) = Power (diopters) x Decentration (cm)]:

_____

Station 3: Distance Visual Acuity

Screener's Name:

◯ Lea ◯ Other

Right Eye	☐ Unable to test	◯ _____/_____	◯ Walk up: _____/_____	◯ Finger counting ◯ Hand motion ◯ Light projection ◯ Light perception ◯ No light perception
Left Eye	☐ Unable to test	◯ _____/_____	◯ Walk up: _____/_____	◯ Finger counting ◯ Hand motion ◯ Light projection ◯ Light perception ◯ No light perception
Distance Both Eyes	☐ Unable to test	_____/_____		

Station 4: Near Visual Acuity

Screener's Name:

◯ Lea ◯ Other

Near VA Both Eyes	☐ Unable to test	_____/_____

Station 5: Stereopsis

Screener's Name:

☐ Unable to test	◯ RDE _____/6	◯ PASS Test 480 sec. of arc _____/5	◯ Other: _____

Station 6: Autorefraction

Screener's Name:

☐ Unable to test **Autorefractor used:** ◯ Retinomax ◯ Spot ◯ Other: _____

	Sphere	Cylinder	Axis	Retinomax reliability rating *(7 or lower indicates invalid results/error)*
Right Eye				
Left Eye				

Station 7: Intraocular Pressure (IOP)

Screener's Name:

☐ Unable to test **Tonometer used:** ◯ Icare Tonometer ◯ Non-Contact Tonometer ◯ Other: _____

Right Eye: _____ **Left Eye**: _____

Station 8: Cover Test

Screener's Name:

Distance					
☐ Unable to test ☐ Latent nystagmus					
○ **Phoria**	☐ Orthophoria				
	○ Eso ○ Exo	Range 2-99_____	○ Right Hyper ○ Right Hypo	Range 2-99_____	
			○ Left Hyper ○ Left Hypo	Range 2-99_____	
○ **Tropia**	○ **Right Eye**	○ Constant ○ Intermittent			
		○ Eso ○ Exo	Range 2-99_____	○ Right Hyper ○ Right Hypo	Range 2-99_____
	○ **Left Eye**	○ Constant ○ Intermittent			
		○ Eso ○ Exo	Range 2-99_____	○ Left Hyper ○ Left Hypo	Range 2-99_____
	○ **Alternating**	○ Constant ○ Intermittent			
		○ Eso ○ Exo	Range 2-99_____	○ Right Hyper ○ Right Hypo	Range 2-99_____
				○ Left Hyper ○ Left Hypo	Range 2-99_____

Near					
☐ Unable to test ☐ Latent nystagmus					
○ **Phoria**	☐ Orthophoria				
	○ Eso ○ Exo	Range 2-99_____	○ Right Hyper ○ Right Hypo	Range 2-99_____	
			○ Left Hyper ○ Left Hypo	Range 2-99_____	
○ **Tropia**	○ **Right Eye**	○ Constant ○ Intermittent			
		○ Eso ○ Exo	Range 2-99_____	○ Right Hyper ○ Right Hypo	Range 2-99_____
	○ **Left Eye**	○ Constant ○ Intermittent			
		○ Eso ○ Exo	Range 2-99_____	○ Left Hyper ○ Left Hypo	Range 2-99_____
	○ **Alternating**	○ Constant ○ Intermittent			
		○ Eso ○ Exo	Range 2-99_____	○ Right Hyper ○ Right Hypo	Range 2-99_____
				○ Left Hyper ○ Left Hypo	Range 2-99_____

Station 9: External Eye Health

Screener's Name:

Right Eye Please select any that apply:			
	○ Unable to test	○ No abnormality detected	○ Abnormality detected
	☐ Nystagmus	☐ Lid anomaly	☐ Blepharitis
	☐ Pterigium/pinguecula	☐ Conjunctivitis	☐ Corneal anomaly
	☐ Iris anomaly	☐ Ptosis	☐ Other: _____

Left Eye Please select any that apply:			
	○ Unable to test	○ No abnormality detected	○ Abnormality detected
	☐ Nystagmus	☐ Lid anomaly	☐ Blepharitis
	☐ Pterigium/pinguecula	☐ Conjunctivitis	☐ Corneal anomaly
	☐ Iris anomaly	☐ Ptosis	☐ Other: _____

Station 10: Pupils

Screener's Name:

◯ Unable to test	◯ No abnormality detected	◯ Abnormality detected
☐ APD (Afferent Pupillary Defect) ◯ Right Eye ◯ Left Eye		
☐ Other: _____		

Station 11: Internal Eye Health

Screener's Name:

Right Eye	Cup to disc ratio_____ (0.1-0.9)		
	◯ Unable to test	◯ No abnormality detected	◯ Abnormality detected
	☐ Cataracts	☐ Retinal anomaly	☐ Coloboma
	☐ Optic nerve anomaly	☐ Glaucoma suspect	☐ Other: _____

Left Eye	Cup to disc ratio_____ (0.1-0.9)		
	◯ Unable to test	◯ No abnormality detected	◯ Abnormality detected
	☐ Cataracts	☐ Retinal anomaly	☐ Coloboma
	☐ Optic nerve anomaly	☐ Glaucoma suspect	☐ Other: _____

Station 12: Retinoscopy & Refraction

Screener's Name:

Distance Retinoscopy			
	Sphere	**Cylinder**	**Axis**
Right Eye			
Left Eye			

Near Retinoscopy			
	Sphere	**Cylinder**	**Axis**
Right Eye			
Left Eye			

Refraction

	Sphere	Cylinder	Axis	Horizontal Prism	Base	Vertical Prism	Base	Add	Visual Acuity	Visual Acuity O.U.
Right Eye									20/	20/
Left Eye									20/	

Screener's Name (if different than Retinoscopy):

Station 13: Check Out

Screener's Name:

Screening Completion

Was the screening unable to be completed and/or concluded prior to completion for any reason?

◯ Screening Complete ◯ Screening Incomplete

If screening incomplete, please describe: _____

Recommendations

◯ New Rx

First time glasses prescribed?

◯ Yes ◯ No

◯ No Rx (i.e., athlete currently does not need glasses or a new prescription)

◯ Duplicate Rx (i.e., athlete must return to lensometry for duplicate PDs, OCs, BC)

Improved visual acuity:

Is best achievable vision improved or maintained versus the athlete's initial distance visual acuity measured during today's visit?

◯ Yes ◯ No

Prescription Eyewear

☐ Multi-Focal
☐ Distance
- ☐ Dress
- ☐ Sport (contact sport only) - Rx Ranges: (+/-14.00 Sph, 4.75 Cyl)
- ☐ Swim (if available/swim team only) - Rx Ranges: (+8.00, -10.00 Sph, 6.00D Cyl)

☐ Near
☐ Plano Sunglasses (only if no Distance Rx recommended)
☐ Plano Sport Goggles (only if no Distance Rx recommended & participates in contact sports)

Final Rx Multi-Focal

	Sphere	Cylinder	Axis	Horizontal Prism	Base	Vertical Prism	Base	Add
Right Eye								
Left Eye								

Final Rx Distance

	Sphere	Cylinder	Axis	Horizontal Prism	Base	Vertical Prism	Base
Right Eye							
Left Eye							

Final Rx Near

	Sphere	Cylinder	Axis	Horizontal Prism	Base	Vertical Prism	Base
Right Eye							
Left Eye							

Referral			
Follow-up recommended? ◯ Yes ◯ No *If yes, please select appropriate provider(s) below and select the most elevated referral type based on results of screening.*			
☐ **Optometrist**	◯ Routine Follow-up	Continue routine care with an **Optometry** provider at a frequency of: _____	
	◯ Non-Urgent Referral	Reasons for Recommendation: _____	
	◯ Urgent Referral	Reasons for Recommendation: _____	
	Please provide Name/Location of Referral: _____		◯ Provider list dispensed
☐ **Ophthalmologist**	◯ Routine Follow-up	Continue routine care with an **Ophthalmology** provider at a frequency of: _____	
	◯ Non-Urgent Referral	Reasons for Recommendation: _____	
	◯ Urgent Referral	Reasons for Recommendation: _____	
	Please provide Name/Location of Referral: _____		◯ Provider list dispensed
☐ **Primary Care Provider**	◯ Non-Urgent Referral	Reasons for Recommendation: _____	
	◯ Urgent Referral	Reasons for Recommendation: _____	
	Please provide Name/Location of Referral: _____		◯ Provider list dispensed
☐ **Other** **(please specify):** _____	◯ Non-Urgent Referral	Reasons for Recommendation: _____	
	◯ Urgent Referral	Reasons for Recommendation: _____	
	Please provide Name/Location of Referral: _____		◯ Provider list dispensed