OE Eye-Connect FOLLOW UP form

OE Eye-Connect Follow up from a past OE event (use HAS form as reference) **Date of event___________**

First Name	Last Name	HAS ID ________________________

Date	O Male O Female	DoB	Age (years) O Not sure
Consultation Date:		O Athlete O Unified partner	Sport(s)
Delegation		SO Program	
Cell phone #		**Number is: O Athlete's O Parent's / Guardian 's**	

Reason for Eye-Connect visit:

O Urgent referral:
O Evaluate new glasses:
O Regular follow-up:

Case History

When was your last eye exam?

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

Health History

O Allergies
O Diabetes
O High Blood Pressure (hypertension)

Do you experience any of the following

☐ Difficulty seeing: ☐ Far ☐ Near
☐ Headaches
How often? ☐ every day ☐ 1-2 times/week ☐ 1-2/month
☐ Sensitivity to light
☐ Double vision: ☐ Far ☐ Near
When did it start? ☐ within last month ☐ longer than a month
☐ Red eye ☐ both eyes ☐ one eye: right left (circle one)
When did it start?
☐ Pain in eye ☐ both eyes ☐ one eye: right left (circle one)
When did it start?
☐ Discharge from eye ☐both eyes ☐one eye: right left (circle)
When did it start? Have you been ill recently?

O Medication:
☐ Did you have an accident where head or eyes were hit: ☐ Yes ☐ No
☐ Have you had a foreign body in the eye that needed to be removed by an eye doctor: ☐ Yes ☐ No

Did you receive new corrective lenses (glasses)? O No O Yes
If yes, are these the glasses you received from the Opening Eyes event? O No O Yes
If yes, do you think that you see better with your new glasses? ☐ Yes ☐ No If no, how is your vision different?
O Blurry: All of the time? ☐ Yes ☐ No Far Only? ☐ Yes ☐ No Near Only? ☐ Yes ☐ No
Other problems with glasses:
O Glasses hurt my eyes/head O Frame is uncomfortable O Glasses are broken or lenses scratched
IF you checked any of the above, how much time did you wear the new glasses after you received them?

Replacement recommended?	☐yes	☐no	Reason:

If athlete was referred for additional care:

Did the athlete make an appointment?	☐yes	Was the treatment successful?	☐yes	☐no	Reasons:
	☐no	Reason(s):			
Additional comments:					

Tentative diagnosis and recommendations after OE Eye-Connect Consultation:

Referral to: ☐ Optometrist ☐ Ophthalmologist ☐ Primary care physician ☐ Neurologist ☐ Other: ___________

Level of urgency: ☐ emergency ☐ urgent ☐ within a week ☐ within 2-3 weeks ☐ Other:

Additional comments:

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CD______________________ **Signature** ______________________**print CD name Date**________________