PROJECT BEST (BETTER EYE HEALTH SERVICES & TREATMENT) —EYE SCREENING FORM

Must include Health Screening Assessment Form - Please attach before receiving eye screening services

Number

State of New Jersey Commission F/T Blind and Visually Impaired
153 Halsey Street – Eye Health and Diabetes Services Unit
Newark, NJ 07102, Phone Number (973) 648-7400, Fax Number (973) 648-3155

Screening Type: ☐ **On-Site** ☐ **AVS** ☐ **Migrant** ☐ **DEDD** ☐ **ECVS**

Site: ___**Penn Medicine Princeton Health**______ **City:** ______________________ **Date:** _____/_____/ _____

Name: ____ Date of Birth: _____/_____/____
First Last Month- day –Year

Address: ____ ☐ **Male** ☐ **Female** ☐ **Did not Self-Identify**

City: ____________________ **State:**______________ **Zip:** ____________ **County:** ________________

Daytime Phone Number:____________________ **Other Phone Number:**_________________________

Email Address: ____

Race/Ethnicity: ☐ White ☐ African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander
☐ Did not Self-Identify Race ☐ Hispanic or Latino

Health Insurance Information:	**Personal Medical History:**
☐ **None** ☐ **Charity Care** ☐ **Medicaid** ☐ **Medicare**	**Diabetes:** ☐ **Yes** ☐ **No**
☐ **Other Insurance, Specify:** ____________________	**If yes,** ☐ **Type I** ☐ **Type II,**
	Duration of Diabetes: _____
Do you wear Glasses/Contact Lens: ☐ **Yes** ☐ **No**	**High Blood Pressure:** ☐ **Yes** ☐ **No**
If Yes: ☐ **Distance** ☐ **Reading** ☐ **Left at Home**	**Glaucoma:** ☐ **Yes** ☐ **No**

Monthly Income: _______________________ **Number of People in Household:** _____________________

Family History (Blood Relatives):
Diabetes: ☐ **Yes** ☐ **No,** **High Blood Pressure** ☐ **Yes** ☐ **No,** **Glaucoma** ☐ **Yes** ☐ **No**

Date of Last Eye Exam: ☐ **Within 1 yr. (1)** ☐ **More than 1 yr. (2)** ☐ **Never (3)** ☐ **Do not know (4)**

Is your vision giving you any problems? If so, Explain:____

Past Eye Problems:____

Other Health Problems & Allergies:____

Medications: ____

Consent and Release: I hereby consent to carry out such procedures deemed necessary for the eye screening as determined by the screening personnel including eye doctor employed by, or under contract with, the New Jersey Commission for the Blind and Visually Impaired. Such procedures are (but not limited to) vision testing, non-contact/contact tonometry, visual field testing, slit lamp and ophthalmoscopy testing. I hold harmless CBVI, screening site, and their professional staff from any and all rights, actions, or claims I may have arising out of this screening and understand that I am fully responsible for the care and treatment of my eyes or for the person for whom I am granting consent and release for. Also, I know that this is an eye screening and information program and not a complete eye examination nor a substitute for a complete eye examination. I understand that eye drops may be used and I understand that it can blur vision temporarily and I should arrange for a ride home. I authorize the release of any medical and/or other information concerning me or my child obtained during this screening to and from the NJ Commission for the Blind and Visually Impaired, screening site, screening sponsor and involved health care providers with the understanding that such release is necessary for the delivery of Commission services and that all records will be treated as privileged and confidential information.

Signature:____________________________ ________________ ______________________________
Client, Parent, or Guardian's Signature Date Print Name if Parent or Guardian

NAME: **DOB:**

THIS SECTION IS FOR SCREENERS ONLY Screener's initials:______________ SITE:

Visual Acuity:	**O.D.**	**O.S.**	**Tonometry:**	**O.D.**	**O.S.**		**O.D.**	**O.S.**
Distance Vision without correction	20/	20/	Intraocular Pressure			Near Vision (if requested by doctor)		
Distance Vision with Present correction	20/	20/	If 22 or more take an additional reading:			(Children under 7 only) Muscle Imbalance (Y/N)		
Distance Vision with Pinhole (20/40 or Worse)	20/	20/						
☐ **Pass** ☐**Fail** ☐**Unable**			☐ **Pass** ☐**Fail** ☐**Unable**			☐ **Pass** ☐**Fail** ☐**Unable**		

Signature:______________________ Signature:______________________ Signature:____________________

DEDD Only: Blood Pressure:______/_____ ☐ **WNL** ☐ Under Care ☐ **Referred** ☐ **Emergency** Signature:__________

THIS SECTION IS FOR EYE DOCTORS ONLY

WARNING: If IOP is more than 22 do not instill Mydriatic drops unless approved and initialized by the doctor; Initials:_____

Eye Drops Utilized_______________________ Signature__________________________________ ☐ **DR.** ☐ **RN.** ☐ **C.O.T.**

	O.D.	**O.S.**
Old Rx		
Manifest		
Cycloplegic		
Add (14B)		
Final		
PD (must)		

Eye Exam	**O.D.**	**O.S.**
(24) Normal/No Etiology		
(03) Cataracts (classify I to IV)		
(05) Corneal/ Scleral Disease (**draw picture for Pterygium)**		
(06a) Background Retinopathy		
(06b) Pre-Proliferative Retinopathy		
(06c) Proliferative Retinopathy/vitreous hemorrhage		
(06d) Maculopathy		
(07) Glaucoma Suspect**, C/D Ratio**		
(09) Macular Degeneration		
(11) Muscular Imbalances		
(13) Optic Nerve Disease		
Color Vision Abnormalities		
(21) Diagnosis Not Known		
(22) Amblyopia		
(23) Other/Not Included In List		
Is eye condition deteriorating?		

Cover Test: Normal ☐ Abnormal ☐ Pupils: PERRLA ☐ Y ☐ N, Confrontation Field: full to FC – OD ☐ OS ☐ Defect ☐

Any comments: ____

Rx Given For: ☐ Eye Glasses ☐ Eye Drops/Medications Treatable: ☐ Yes ☐ No Legally Blind: ☐ Yes ☐ No

Treatment Indicated: ____

Should seek treatment within: ☐ **Emergency same day** ☐ 1 week ☐ 1 month ☐ 3 months ☐ 1 year

__________________________ ____ ______________________

Doctor's Name (Print) Doctor's Signature Date

Findings: ☐ **PASS (within screening guidelines)** ☐ Abnormal Visual Acuity ☐ Glaucoma Suspect ☐ Cataract ☐ Muscle Imbalance
☐ Diabetic Retinopathy ☐ Trauma ☐ other eye condition ________________ ☐ Medical Referral ☐ Unable

Referral: ☐ No Referral ☐ Other Resources (for glasses) ☐ Other Resources (for evaluation) ☐ CBVI Services
☐ CBVI Fixed Site ☐ On-site doctor (for AVS) ☐ Private Eye Doctor ☐ Previous CBVI client
☐ Emergency room ☐ FQHC ☐ Self-Help / Support group

For VR Referral: Working ☐ **Yes** ☐ **No**, If yes - P/T ☐ or F/T ☐, If No - Do you want to work? ☐ **Yes** ☐ **No**

Is change in Vision interfering doing your job? ☐ **Yes** ☐ **No** Do you need help to obtain a job? ☐ **Yes** ☐ **No**

Social Security #: ____, ☐ **None**

Treatment Received: ☐ Yes ☐ No, if No, Reason ____

Source: ☐ CBVI Services ʘ CBVI Fixed Site ʘ On-Site Doctor ☐ Letter from Doctor ☐ Phone call ☐ Other