Vision Screening – Birth to Age 3

Scoring the
Parent Questionnaire

PARENT QUESTIONNAIRE

PRACTICE 1 – MELISSA RODRIGUEZ

(Please print prior to training session)

A Shared Vision
Partners in Pediatric Blindness & Visual Impairment

Vision Screening Parent Questionnaire for Children Birth to Age Three

This questionnaire will help gather valuable information about your child's vision. If there are possible vision concerns, we will discuss these with you and whether a visit to a vision professional is needed. This form should be completed by the person who knows your child and family medical history the best. **Please return the completed questionnaire to the email address provided at the end of the document prior to your Early Intervention Evaluation meeting.** If you cannot email the completed questionnaire, please bring it with you to your scheduled meeting.

Child's Name:	Melissa Rodriguez	Child's DOB	
Caregiver's Name:		Today's Date:	
Organization:			
Contact Person:		Contact Person's Email:	

Family Vision History (Parents and Siblings)

Is there family history of eye crossing (strabismus) or vision loss due to eye crossing (amblyopia) – grandparent, parents, siblings?	Yes ■	No ☐
Did anyone in your family need prescription glasses before age 6 years?	Yes ☐	No ■
Please describe any other family vision problems (e.g., retinoblastoma, born with cataracts or glaucoma, etc.).		

Child's Medical History

Has your child been affected by or diagnosed with any of the following? Leave blank if you are unsure or don't know.

Prematurity (i.e., born before 32 weeks).	Yes ■	No ☐
Birth weight less than 4.5 pounds.	Yes ☐	No ■
Needed oxygen more than 4 days as a newborn.	Yes ☐	No ■
Hearing loss.	Yes ☐	No ■
Head or facial differences at birth (e.g., cleft lip/palate, craniosynostosis, etc.).	Yes ☐	No ■
Prenatal exposure to infections (e.g., CMV, syphilis, rubella, toxoplasmosis, etc.).	Yes ☐	No ■
Meningitis or encephalitis.	Yes ☐	No ■
Prenatal exposure to drugs or alcohol.	Yes ☐	No ■
Any type of syndrome (e.g., Down Syndrome, CHARGE Syndrome, etc.).	Yes ☐	No ■
Brain injury (e.g., lack of oxygen, stroke, accidental or non-accidental trauma, etc.).	Yes ☐	No ■
Neurological conditions (e.g., cerebral palsy, infantile spasms or other seizure disorders, hydrocephalus, etc.).	Yes ☐	No ■
Delayed Visual Maturation or Cortical/Cerebral Visual Impairment (CVI).	Yes ☐	No ■

Eye Doctor Examination

Has an eye doctor examined your child's eyes?	Yes ☐	No ■
If yes, when was the most recent exam (month, year)?		
What were the results of the exam?		
Were eyeglasses or another treatment prescribed?	Yes ☐	No ☐
If the doctor prescribed eyeglasses, does your child wear them?	Yes ☐	No ☐
If your child does not wear their glasses, what is the reason?		

We can learn a lot about the health of your child's vision by looking at the appearance of their eyes and eyelids, observing their visual behaviors, and listening to your concerns about your child's vision.

Appearance of Eyes and Eyelids

Please take a few moments to look at your child's eyes and eyelids. Answer yes or no to the following questions. If you are unsure, leave the question blank.

Does one eye look different than the other eye? For example, one eye looks much smaller, or one eye is higher on the face than the other eye.	Yes ☐	No ■
Do one or both eyes turn in, out, up, or down? This may happen all of the time or only some of the time.	Yes ☐	No ■
Is there a difference in the black color, size, or shape of the pupils in one or both eyes? The pupil is the dark black center of each eye.	Yes ☐	No ■
Is there a difference in the size and shape of the iris in one or both eyes? The iris is the colored part of each eye.	Yes ☐	No ■
Do one or both of their eyes appear white or cloudy?	Yes ☐	No ■
Do their eyes involuntarily move or rapidly move – dancing/ jiggling up and down or side to side?	Yes ☐	No ■
Are their eye(s) red and/or excessively mattered beyond the usual sleep matter when the child first awakens or due to allergies?	Yes ☐	No ■
Are their eyelids red, swollen, and/or encrusted?	Yes ☐	No ■
Does one eyelid droop or appear lower than the other?	Yes ☐	No ■

If you answered "yes" to any of the questions above, when did you first notice it? Did this happen suddenly? Please describe.

Behaviors

Your child's actions may indicate that something may not be right with their vision. Please think about how your child uses their vision during the day. Answer yes or no to the statements below. If you are unsure, leave the statement blank.

My child…

Answer the following statement for children one month or older

1. Has difficulty looking at and making eye contact with me for at least 3 seconds.	Yes ☐	No ■

And answer the following statements for children three months or older

2. Tilts or turns their head to the side, lifts or lowers their chin, and/or thrusts their head forward or backward when looking at something at near or far range. Circle which behavior you notice.	Yes ☐	No ■
3. Holds an object very close to their eyes (within 1-4 inches) when looking at it.	Yes ☐	No ■
4. Has trouble seeing small objects such as a piece of lint, or a small piece of cereal left on a tray or table.	Yes ☐	No ■
5. Frowns, squints, or covers an eye when looking at something at near or far distance.	Yes ☐	No ■

6. Appears to be looking over, under, or beside people or objects rather than looking straight at them.	Yes ☐	No ■
7. Shows more interest in looking at overhead lights or windows than looking at people or toys.	Yes ☐	No ■
8. Struggles to recognize familiar people before hearing their voices.	Yes ☐	No ■
9. Recognizes a familiar toy only after touching or hearing it.	Yes ■	No ☐
10. Only sees an object when it is separated from other items. For example, cannot find a specific toy when it is among other objects.	Yes ☐	No ■
11. Notices people, pets, or objects only when they are moving.	Yes ☐	No ■
12. Looks away when reaching toward a nearby object.	Yes ☐	No ■
13. Reaches over or under something when they are trying to grasp it.	Yes ☐	No ■

And answer the following statements for children who are 12 months or older

14. Has difficulty detecting a change in a floor surface, such as from tile to carpet.	Yes ☐	No ■
15. Frequently stumbles over objects or bumps into things that are in their path. Hesitates or misses detecting a step or a curb.	Yes ☐	No ■
16. Avoids looking at or pointing to pictures in books or on a screen.	Yes ☐	No ■
17. Has a hard time finding small details in pictures (e.g., when asked to point to a dog's nose).	Yes ☐	No ■
18. Has difficulty seeing or pointing to something over 20 feet away, such as a dog across the street, an airplane flying overhead.	Yes ☐	No ■

Caregiver Concerns

Do you have any concerns about your child's vision that were not addressed in the earlier questions?
If yes, please describe.

No concerns

Next Steps:

Please return this questionnaire to the email address below prior to your evaluation or meeting. If you cannot email the completed questionnaire, please bring it with you to your meeting.

To Be Completed by Vision Screening Professional – when was Parent Questionnaire completed?

☒ EI Evaluation ☐ IFSP (initial, annual, periodic review) ☐ Other

References:

Colorado Department of Education (2005). *Visual Screening Guidelines: Children Birth through Five Years.*

Teach CVI (2020). *Screening List for Children with a Suspicions of a Cerebral Visual Impairment (CVI) / Screen List CVI 1.* Click HERE for the document.

Topor, I. (2004). *Approximate functional visual acuity for different sizes of objects and distances*. Chapel Hill, NC: Early Intervention Training Center for Infants and Toddlers with Visual Impairments, FPG Child Development Institute, UNC-CH.

A Shared Vision
Partners in Pediatric Blindness & Visual Impairment

Vision Screening – Birth to Age 3

Vision Screening Parent Questionnaire (Updated 2022) Scoring Guidance

Child's Name:		DOB:	
Evaluator Name:		Today's Date:	

INTRODUCTION

The screening process is designed to answer one simple question, **"Is there a vision concern that requires further examination by a pediatric eye doctor?"**

The information collected in the Vision Screening Parent Questionnaire is important in helping to identify children who may require further evaluation. Screeners are looking for both ocular and neurological indications of vision concerns. The questionnaire is not intended to diagnose medical conditions. It is not a comprehensive assessment or a guide for educational programming.

The questionnaire and scoring should take about 10 minutes to complete by a qualified, experienced professional.

Successful completion of vision screening training is required before using this "Vision Screening Parent Questionnaire – Scoring Guidance." Contact A Shared Vision for training or support.

Note, if a child is currently receiving early intervention vision services from an Early Intervention Teacher of the Visually Impaired (EI-TVI), then you do not need to complete this screening process.

RECOMMENDED PROCESS

1.	2.	3.	4.	5.	6.	7.
Send or give "Parent Questionnaire" to caregivers to complete before meeting.	Score "Parent Questionnaire" Clarify caregivers' responses, if needed.	Fill out "Results and Next Steps for Caregivers." Give form to caregivers.	Help caregivers understand telehealth vs. in-person visits with pediatric eye doctor.	Provide other valuable information to caregivers.	Request the eye doctor's report, if appropriate, and place in child's file.	Place copy of completed "Parent Questionnaire" and "Next Steps" in file.

AS YOU'RE GETTING STARTED WITH THE VISION SCREENING PROCESS

Under certain circumstances an **urgent** recommendation for follow up with a pediatric ophthalmologist is highly recommended. These include:

- One eye looks different than the other eye (e.g., one eye is significantly smaller in appearance, or one eye is higher on the face than the other eye).
- One or both eyes turn inward or outward. This can happen all of the time or only some of the time. This is urgent if abrupt onset for a child 2-3 years old.
- There is a difference in the black color, size, or shape of the pupils in one or both eyes. This is urgent if the size of the unequal pupil is more than one millimeter.
- There is a difference in the size or shape of the iris in one or both eyes. This is urgent if the size of the unequal iris is more than one millimeter.
- One of both eyes appear cloudy or white.
- Eye movement is involuntary, with rapid (dancing/ jiggling up and down or side to side) motion. This is urgent if abrupt onset.

If any of these circumstances exist, complete review of the questionnaire, and then instruct the caregivers to call a pediatric ophthalmologist within 1 to 2 days. The information gathered in the questionnaire will provide important documentation for the pediatric eye doctor and EI-TVI.

SCORING INSTRUCTIONS

Family Vision History (Parents and Siblings)

If there are **one or more** positive responses ("yes"), select Concerns Identified.

☐	No Concerns
☐	Concerns Identified: Child is at higher risk for visual impairment.

Child's Medical History

If there are **one or more** positive responses ("yes"), select Concerns Identified.

☐	No Concerns
☐	Concerns Identified: Child is at higher risk for visual impairment.

Eye Doctor Examination

This information is not scored. However, if an eye report is available, please request the form to add to the child's file.

Appearance of Eyes and Eyelids

If there are **one or more** positive responses ("yes"), select either Non-urgent or Urgent Concerns Identified.

☐	No Concerns
☐	Non-urgent Concerns Identified: Recommend follow up with pediatric ophthalmologist or pediatric optometrist.
☐	Urgent Concerns Identified: Recommend follow up with pediatric ophthalmologist.

Objective Test

If there are **one or more** positive responses ("yes"), select Concerns Identified.

☐	No Concerns
☐	Concerns: Recommend follow up with pediatric ophthalmologist or pediatric optometrist.

Behaviors – automatic referral if "yes" answer to any of questions 1-5

If there are **one or more** positive responses ("yes"), select Concerns Identified.

☐	No Concerns
☐	Concerns Identified: Recommend follow up with pediatric ophthalmologist to discuss possible neurological visual impairment.

Behaviors – referral if two or more "yes" answers to questions 1-18

If there are **TWO or more** positive responses ("yes"), select Concerns Identified.

☐	No Concerns: If one or no "yes" answers to questions 1 thru 18, then no concerns.
☐	Concerns Identified: Recommend follow with pediatric ophthalmologist if two or more "yes" answers to questions 1 thru 18 to discuss possible neurological visual impairment.

Caregiver Concerns

If there are **one or more** positive responses ("yes"), select Concerns Identified.

☐	No Concerns
☐	Concerns Identified: If child is enrolled in early intervention, then consider adding vision services on IFSP for EI-TVI to discuss concerns with caregiver. Otherwise, refer family to pediatrician or other PCP doctor.

WRAP-UP

1. Fill out the "Vision Screening Results & Next Steps for Caregivers" form.
2. Provide caregivers with a copy of the completed form and review action plan.
3. If a recommendation for follow up with an eye doctor is suggested and child has been seen by an eye doctor, then request the eye doctor's report to place in the child's file.

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Vision Screening for Children Birth to Age Three
Results Summary and Referral Recommendations
Rubric

Place an "X" in the appropriate column for each section of the Vision Screening protocol to determine appropriate referral and next steps.

Screening Component	No Concerns	Concerns Identified	Next Steps Recommendation(s)
Family Vision History	☐	☐	**No referral** – If no other concerns are identified, indicate "No observable vision problems. However some risk factors exist."
Child's Medical History	☐	☐	
Appearance of Eyes and Eyelids (non-urgent)	☐	☐	**Refer – recommend non-urgent** follow up with a pediatric ophthalmologist or optometrist. (Consider vision services on IFSP.)
Appearance of Eyes and Eyelids (**urgent**)		☐	**Refer – recommend URGENT** follow up with a pediatric ophthalmologist. (Consider vision services on IFSP.)
Objective Testing (fixation, visual tracking, pupillary reflex, corneal light reflection, instrument-based screening)	☐	☐	**Refer – recommend non-urgent** follow up with a pediatric ophthalmologist or optometrist. (Consider vision services on IFSP.)
Behaviors (1-5)	☐	☐	**Refer – recommend non-urgent** follow up with a pediatric ophthalmologist. (Consider vision services on IFSP.)
Behaviors (two+ 1-18)	☐	☐	
Caregiver Concerns	☐	☐	**Refer –** If child is enrolled in early intervention, then consider vision services on IFSP for EI-TVI to discuss concerns with caregiver. Otherwise, refer family to pediatrician or other PCP doctor.

Contact Information for Pediatric Ophthalmologists and Optometrists

See list of pediatric eye doctors at https://www.asharedvision.org/pediatric-eye-doctors-in-colorado.html

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Vision Screening – Birth to Age 3
Vision Screening Results & Recommend Next Steps for Caregivers

Screening Professional:		Screening Date:	
Child's Name:		DOB:	

Screening Results and Recommended Next Steps

☐ **No further action required at this time.**
Rescreen annually or sooner if any concerns arise.

☐ **No observable vision problems. However, some risk factors are present, e.g., family history and/or medical risk factors.**
- Provide developmental milestones specific to vision to caregivers for reference.
- If concerns arise, discuss with a pediatric ophthalmologist, optometrist, or PCP.
- Rescreen annually.

☐ **Vision concerns are observed.**
- Describe vision concerns (use the back of this page if more room is needed):
  _____
- Recommend contacting a pediatric ophthalmologist or optometrist for follow-up.
- Consider support from an Early Intervention Teacher of the Visually Impaired.

☐ **Urgent vision concerns are observed.**
- Describe vision concerns (use the back of this page if more room is needed):
  _____
- Recommend contacting a pediatric ophthalmologist for **immediate** follow-up.
- Consider support from an Early Intervention Teacher of the Visually Impaired.

Provide this document to caregivers at the conclusion of vision screening.