



Lions of Michigan FOUNDATION Referred Child Report Form



Dear Parent or Guardian:

We have determined that your child might have a vision problem that requires further testing by an eye care professional. Our handheld autorefractors are extremely accurate at identifying vision loss in children, however, vision screening results are only preliminary evidence of a vision problem and must be verified by an eye care professional as soon as possible. If your child is already being treated by an eye doctor, please complete as much of this form as possible and return the form to our office. However, if your child is not currently being treated by an eye doctor, please schedule an appointment with an eye doctor and ask the eye doctor to complete and return this form to our office following your child's eye care appointment. The completed form can be faxed to 517-887-6642, completed and submitted online at (<https://www.lmsf.net/index.php/en/programs/project-kidsight>) or mailed to 5730 Executive Drive – Lansing, Michigan 48911.

For our KidSight Program to reach its fullest potential, we must ensure that the children who we refer for further testing receive treatment for their eye care needs. The support of parents, guardians, and eye care professionals is instrumental to the success of KidSight. If your family needs help obtaining eye care for your child, please contact our office (517-887-6640 – info@lmsf.net) or the Michigan Department of Health and Human Services (517-241-3740 – <https://www.michigan.gov/mdhhs>) to inquire about eye care assistance programs.

Dr. John (Jack) Baker, MD - Chief Medical Director – KidSight-Michigan

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Vision Screening Date: _____ Screening Location: _____

Referred Child: _____ Date of Birth: _____

Referral Reason(s): Myopia ☐ Hyperopia ☐ Anisometropia ☐ Astigmatism ☐ Anisocoria ☐
Gaze ☐ Unreadable ☐ Other _____

____ The child already wears eyeglasses, but the child received a referral result while wearing their eyeglasses.

Child's Parent or Guardian: _____

Telephone: _____ Email Address: _____

____ My child is already being treated by an eye care professional.

____ The eye doctor is treating my child with: Glasses ☐ Patching ☐ Other _____

Eye Doctor: _____ Title: MD ____ DO ____ OD ____

Telephone: _____ Email Address: _____

Our office examined the child for the first time on the date of: _____

Diagnosis: Amblyopia ☐ Amblyogenic Risk Factors ☐ Anisometropia ☐ Myopia ☐ Hyperopia ☐
Astigmatism ☐ Anisocoria ☐ Strabismus ☐ Other _____

Treatment: None ☐ Glasses ☐ Patching ☐ Follow-up ☐ Other _____

In the eye doctor's opinion, were the results of the KidSight Vision Screening accurate? Yes ☐ No ☐

In the eye doctor's opinion, was the Project KidSight referral warranted? Yes ☐ No ☐

Explanation: _____