Eye Specialist _____

MCCSB **069.01** Initial **Address** _____

069.02 Annual **Phone** _____

MARION COUNTY CHILDREN SERVICES
EYE SPECIALIST FORM
(Attention Office Manager – Please fax this form to CSB upon completion.)

CHILD'S NAME: _____ **DATE** _____

Visual Acuity: With Glasses **R** _____ **L** _____ **Both** _____

Without Glasses **R** _____ **L** _____ **Both** _____

Diagnosis, if indicated: _____

_____

Glasses Prescribed: **Yes** _____ **No** _____

Recommendation for wearing glasses: _____

_____

Comments: _____

SIGNED: _____
Specialist

		SPHERE	CYLINDER	AXIS	PRISM	BASE	ORTHOGON
Distance	**R**						
	L						**Softlite 1-2-3-4** **Rayban 1-2-3**
Reading Add	**R**		Other Lens Instruction:				**Panoptik** **Univis**
	L						**Orthogon – D** **Univis CV-L**

Panoptik Tri-Fl

Initial Custody Date _____ Expected Date of Initial Exam _____ Expected Date of Next Exam _____

_____ **O.D.**
Signature

Copies to: Child's Caseworker CSB Receptionist Foster Parent

Rev: 8-29-05