InfantSEE Clinical Reporting Form
http://exam.infantsee.org

Date of Assessment __/__/__

Gender: □ M □ F Year of Birth ________________

Patient State__________________________________________

Birth History: Born Premature? □ Yes □ No If yes: born at how many weeks premature______________

Delivery Complications:____________________________________

Ethnic Origin: □ Hispanic □ Caucasian □ African American □ Native American □ Asian □ Other

Insurance: □ Yes □ No If yes: □ Private □ CHIP □ Medicaid □ Other, specify_________________________

How did you find out about InfantSEE?

□ Current Patient □ Radio □ Parenting Classes
□ Friend/Family □ Internet □ Other, specify __________________________
□ Mail □ Newspaper
□ TV □ Primary Health Provider

Medical History__________________________________________

__________________________________________

ASSESSMENT (Use InfantSEE® Clinical Assessment Criteria)

Ocular Motility □ No Concern □ Concern □ Problem __________________________

Binocularity □ No Concern □ Concern □ Problem __________________________

Refractive Status □ No Concern □ Concern □ Problem __________________________

Visual Acuity □ No Concern □ Concern □ Problem __________________________

Ocular Health □ No Concern □ Problem __________________________

Dilation □ Yes □ No

Plan □ No Concerns
□ Concerns and in need of follow up care in_________ months or ________ weeks

Referral to:__________________________________________

Recommended follow-up:___________years of age

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Please enter Clinical Reporting Form online at www.infantsee.org
or mail to: 243 N. Lindbergh Blvd., St. Louis, MO 63141 or fax to: 314.991.4101
For questions Call: 314.983.4286 or email: infantsee@aoa.org