InfantSEE Clinical Reporting Form

InfantSEE Provider Information

O.D. Name: ____________________________  ____________________________
AOA I.D. Number: ____________________________
O.D. State: __________  O.D. Zip: __________

Patient Information

Gender:  □ M  □ F

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

How did parent find out about InfantSEE?

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

Assessment Information

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 ____________________________

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