InfantSEE® Clinical Reporting Form

http://exam.infantsee.org

Date of Exam _____/ _____/ _____

Gender: ☐ M ☐ F **Date of Birth** _____/_____/_____ **Age** (in Months):_____

Patient City_____ **State**_____ **Zip** _____

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
☐ Friend/Family
☐ Mail
☐ TV
☐ Radio
☐ Internet
☐ Newspaper
☐ Primary Health Provider
☐ Parenting Classes
☐ Other, specify _____

Yearly Household Income: (Required for HRSA Grant States Only)

☐ Less than $20,000
☐ $20,000-$39,999
☐ $40,000-$59,999
☐ $60,000-$79,999
☐ $80,000-$99,999
☐ More than $100,000

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

OD Name/AOA Number	State	Zip Code	Date

If unable to enter online, mail to: 243 N. Lindbergh Blvd., St. Louis, MO 63141 or fax to: (314) 991-4101
For questions Call: (800) 365-2219, ext. 4286 or write to: infantsee@aoa.org