



[Service provider logo]	Name of screener
	Date of screen
	Location

1. Information about the person			
Family name		Given names	
Date of birth	Age: 0-3 <input type="checkbox"/> 4-39 <input type="checkbox"/> 40+ <input type="checkbox"/>	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>	
Address			
Phone/email		Consent: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Parent/caregiver details			
Family name		Given names	
Phone/email		Consent: Yes <input type="checkbox"/> No <input type="checkbox"/>	

2. Pre-screening questions	Yes	No	Action
If a young child, was the child pre-term or low birth weight?	<input type="checkbox"/>	<input type="checkbox"/>	Yes Stop screen and Refer to eye health professional urgently
Do you have pain, discharge or itchiness in the eye?	<input type="checkbox"/>	<input type="checkbox"/>	Yes → Which do you have? Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Itchiness <input type="checkbox"/>
Do you have an eye injury?	<input type="checkbox"/>	<input type="checkbox"/>	Yes → What caused the injury? Chemicals <input type="checkbox"/> Stop screen, wash out eye, then continue Burn/hot liquid <input type="checkbox"/> Foreign body <input type="checkbox"/> Knock or cut <input type="checkbox"/>
Do you have blurred vision or any other symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	Yes → Record details in notes
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Yes and a problem is identified during screening or person is not under care of a diabetes service Refer to eye health professional or diabetes service.
Do you currently receive care from an eye health professional?	<input type="checkbox"/>	<input type="checkbox"/>	Yes , and a problem identified during screening Refer to eye health professional at service person is already using.
Do you wear spectacles? Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes → What are the spectacles used for?		Yes , and a problem is identified during screening Refer to eye health professional at service person is already using.
	Seeing things in the distance <input type="checkbox"/>		→ Ask person to wear for distance vision screen
	Seeing things that are near <input type="checkbox"/>		→ Ask person to wear for near vision screen
	Both distance and near <input type="checkbox"/>		→ Ask person to wear for both distance and near vision screen
	Do not know <input type="checkbox"/>		→ Ask person not to wear for any vision screen
Notes			

3. Vision screen

Fundus reflex screen <i>Children 3 years and under only</i>				Action
Do both eyes have a healthy fundus reflex? Yes <input type="checkbox"/> No <input type="checkbox"/>	No → Why?		No → Refer to eye health professional urgently	
	Unhealthy colour or brightness: Right eye <input type="checkbox"/> Left eye <input type="checkbox"/>			
	No fundus reflex: Right eye <input type="checkbox"/> Left eye <input type="checkbox"/>			
Distance vision screen <i>Adults and children over 3 years only</i>				
Chart:	3–8 years <input type="checkbox"/> → HOTV Older than 8 years <input type="checkbox"/> → Distance E-chart			
Spectacles:	If the person wears spectacles for distance vision, are they wearing them for screen?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Right eye: Top line	Result	Right eye: Bottom line	Action	
Matches 2 or more letters correctly on top line: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes → Continue to bottom line No → Continue to left eye	Matches 3 or more letters correctly on bottom line: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes to all, both eyes <input type="checkbox"/> And: Under 40 years → Skip to eye health screen 40 years or older → Continue to near vision screen	
Left eye: Top line	Result	Left eye: Bottom line	No to either eye <input type="checkbox"/> Top line → Skip to eye health screen and → Refer to eye health professional urgently Bottom line → Skip to eye health screen and → Refer to eye health professional	
Matches 2 or more letters correctly on top line: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes → Continue to bottom line No → Continue to eye health screen	Matches 3 or more letters correctly on bottom line: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Unable to complete distance vision screen <input type="checkbox"/>			→ Skip to eye health screen and → Refer to eye health professional	
Near vision screen <i>Adults 40 years and older only</i>				
Spectacles:	If the person wears spectacles for near vision, are they wearing them for screen?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Correctly indicates the direction of 3 or more E's on the Near E-chart: Yes <input type="checkbox"/> No <input type="checkbox"/>			No → Assess for near vision spectacles. If not available → Refer to eye health professional	
Unable to complete near vision screen <input type="checkbox"/>			→ Refer to eye health professional	
For a summary of how to manage vision problems			→ Guide one: Vision problems	

4. Eye health screen				Action
Do both eyes look healthy? Yes <input type="checkbox"/> No <input type="checkbox"/>				Yes → Skip to Action taken No → Record why below
Eye health problems		Right	Left	Action
Signs of a red eye problem	Redness	<input type="checkbox"/>	<input type="checkbox"/>	→ Guide two: Red eye problems
	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Signs of an external eye problem	Crust on eyelids/lashes	<input type="checkbox"/>	<input type="checkbox"/>	→ Guide three: External eye problems
	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
	Lump(s)	<input type="checkbox"/>	<input type="checkbox"/>	

	Eyelashes turn inwards	<input type="checkbox"/>	<input type="checkbox"/>	
Signs of another eye problem	Coloured part of eye unclear/milky	<input type="checkbox"/>	<input type="checkbox"/>	👉 Refer to eye health professional
	Eyes not looking in same direction	<input type="checkbox"/>	<input type="checkbox"/>	
	Other ✎	<input type="checkbox"/>	<input type="checkbox"/>	
0-3 years and any of the above <input type="checkbox"/>				→ Guide four: Children 3 years and under
Signs of an eye injury	Chemical	<input type="checkbox"/>	<input type="checkbox"/>	→ Guide five: Eye injuries
	Burn	<input type="checkbox"/>	<input type="checkbox"/>	
	Foreign body	<input type="checkbox"/>	<input type="checkbox"/>	
	Knock or cut	<input type="checkbox"/>	<input type="checkbox"/>	
Unable to complete eye health screen <input type="checkbox"/>				👉 Refer to eye health professional

5. Action taken			
Taught:	Eye health education <input type="checkbox"/>		
Performed:	Eye wash out <input type="checkbox"/> Foreign body removal <input type="checkbox"/> Eyelid and lash cleaning <input type="checkbox"/> Eyelash removal <input type="checkbox"/> Pupil reactions test: Pass <input type="checkbox"/> / Did not pass <input type="checkbox"/> Eye movements test: Pass <input type="checkbox"/> / Did not pass <input type="checkbox"/>		
Provided:	Warm compress <input type="checkbox"/> Eye pad <input type="checkbox"/> Eye shield <input type="checkbox"/> Near vision spectacles: _____ Power ✎ _____	Medication: Type ✎ _____ Dose ✎ _____ Instructions ✎ _____ _____	
Notes:	✎ _____		
Referred to:	Eye health professional <input type="checkbox"/> Health professional <input type="checkbox"/> Diabetes service <input type="checkbox"/> Other ✎ _____ Reason ✎ _____	Urgent: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Follow up:	No <input type="checkbox"/> Yes <input type="checkbox"/> → Date ✎ _____		

6. Follow up	
Reason: No change <input type="checkbox"/> Worsening symptoms <input type="checkbox"/> Other <input type="checkbox"/>	Date returned ✎
Details ✎	
Further action taken ✎	