LUMINA VISION THERAPY

Jessica Ships O.D.
Optometric Physician
Pediatric and Vision Therapy Services

Checklist for VT referral

Please check any of the following behaviors that you have noticed or that the child complains about:

___ blurred distance vision
___ double vision
___ closes or covers one eye during reading
___ eye turns in, out, up, or down
___ fatigue during near visual tasks
___ squints or blinks excessively
___ holds book or paper too close
___ loss of place when reading
___ uses finger or underliner to read
___ poor eye-hand coordination
___ difficulty with similarities and differences in letters, pictures, or words
___ doesn't complete seatwork or tests on time
___ blurred vision during reading
___ words moving or running together
___ tilts head
___ frequent headaches
___ eye strain
___ rubs eyes during reading and close work
___ avoids close work
___ skips or rereads lines
___ frequent reversals
___ poor depth perception
___ poor attention span during reading or desk work

Please check if this student has difficulties in any of the following areas:

___ reading
___ spelling
___ behavior or motivation
___ handwriting
___ copying from the board
___ math
___ attention span

Please check if any of the following aspects of reading are difficult or are behaviors you have noted during reading:

___ comprehension
___ word recognition
___ phonics/decoding
___ fluency
___ slow reading
___ uses finger
___ loss of place
___ comprehension declines the longer they read
___ avoidance
___ fatigue
___ omits small words

If this child is having reading difficulty, what grade level would you estimate they are reading on?

_____

Dr. Jessica Ships: LIC #5655
Optometrist

Member of: Massachusetts Optometric Association,
American Optometric Association
College of Optometrists in Vision Development

Visual tracking
Binocular vision
Amblyopia
Visual Perception
Learning Related Vision Problems
Neuro-rehabilitation

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If they have difficulty with reading comprehension, do you feel listening comprehension is any better than reading comprehension?

_____

Do you feel this child is performing up to their potential in school? Yes ____ No ____

Does this child enjoy reading for pleasure? Yes ____ No ____

Is this child receiving any tutoring, extra help or special classes in school?

Yes ____ No ____ If yes, please describe:

_____

_____

_____

Please add any other observations or concerns that you have that you would like us to know about in determining if this child has a learning-related vision problem.

Student name: _____

Parent name and phone number: _____

Teacher/Tutor name: _____

School/Practice: _____

School/Practice address: _____

_____

School/Practice phone number: _____

Please include your email address if you would like a copy of the report. We will ask for parent permission before doing this.

_____

Thank you very much for your help.

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