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

Race and Ethnicity: □ Hispanic or Latino Origin □ White □ Black/African American □ American Indian or Alaska Native □ Asian □ Other

How did parent find out about InfantSEE?

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

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