BRUCE GREY CHILD & FAMILY SERVICES

REPORT OF EYE CONDITION

Child's name:		**Worker:**	
Date of Birth:		**Foster Parent:**	
Sex:		**Date of Exam:**	
Referred by:		**Health Card #:**	
Reason for referral:			

	Vision		**With Glasses**
Right Eye:		**Right Eye:**	
Left Eye:		**Left Eye:**	

Is sight likely to improve? _____ **or Decline?** _____ **or Remain as at present?** _____

Diagnosis:

Are glasses required? **Yes** _____ **No** _____

Treatment Received to Date and Remarks:

Advice as to Treatment and Follow-Up:

Optometrist/Ophthalmologist

Name Signature Date