INITIAL

4945 N. 30th St., Third Floor
Colorado Springs, CO 80919

Vision Examination Form (Within 8 weeks of Admission)

Child's Name:_____ Date of Birth:_____

Name of Care Provider:_____ Date of Exam:_____

		Sphere	Cylinder	Axis	Prism	Base	Decentration In	Out
Distance	R							
	L							

		Segment Power	Height	Width	Inset	Total Inset and Decentration
Add	R					
	L					

	DBL	Lens Size (box) & Shape
PD Far Near		

Instructions:_____

_____

_____

Medications Prescribed:_____

Examining Physician's Signature _____ Date:_____

Please print or type:_____
(physician's name)

Address of Care Provider:_____

Phone Number of Care Provider:_____

Please fax to Hope & Home (719) 575 0553 or submit to the Foster Family.
If you have your own office forms, please attach them to Hope & Home's form when submitting.