PROJECT BEST (BETTER EYE HEALTH SERVICES & TREATMENT) —EYE SCREENING FORM

Must include Health Screening Assessment Form - Please attach before receiving eye screening services

State of New Jersey Commission F/T Blind and Visually Impaired
153 Halsey Street – Eye Health and Diabetes Services Unit
Newark, NJ 07102, Phone Number (973) 648-7400, Fax Number (973) 648-3155

Number

Screening Type: AVS

Site: ___ School #6**_____City:____Passaic_____ Screening Date: __2/3/26_____**

Name: _____ Date of Birth: _____/_____/____
First Last Month- day –Year

Address: _____ ☐ **Male** ☐ **Female** ☐ **Did not Self-Identify**

City: _____ State:_____ Zip: _____ County: _____

Daytime Phone Number:_____ Other Phone Number:_____

Email Address: _____

Race/Ethnicity: ☐ White ☐ African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Did not Self-Identify Race ☐ Hispanic or Latino

Health Insurance Information:	**Personal Medical History:**
☐ **None** ☐ **Charity Care** ☐ **Medicaid** ☐ **Medicare** ☐ **Other Insurance, Specify: _____**	**Diabetes:** ☐ **Yes** ☐ **No** **If yes,** ☐ **Type I** ☐ **Type II,** **Duration of Diabetes: _____**
Do you wear Glasses/Contact Lens: ☐ **Yes** ☐ **No** **If Yes:** ☐ **Distance** ☐ **Reading** ☐ **Left at Home**	**High Blood Pressure:** ☐ **Yes** ☐ **No** **Glaucoma:** ☐ **Yes** ☐ **No**

Date of Last Eye Exam: ☐ **Within 1 yr. (1)** ☐ **More than 1 yr. (2)** ☐ **Never (3)** ☐ **Do not know (4)**

Consent and Release: I hereby consent to carry out such procedures deemed necessary for the eye screening as determined by the screening personnel including eye doctor employed by, or under contract with, the New Jersey Commission for the Blind and Visually Impaired. Such procedures are (but not limited to) vision testing, non-contact/contact tonometry, visual field testing, slit lamp and ophthalmoscopy testing. I hold harmless CBVI, screening site, and their professional staff from any and all rights, actions, or claims I may have arising out of this screening and understand that I am fully responsible for the care and treatment of my eyes or for the person for whom I am granting consent and release for. Also, I know that this is an eye screening and information program and not a complete eye examination nor a substitute for a complete eye examination. I understand that eye drops may be used and I understand that it can blur vision temporarily and I should arrange for a ride home. I authorize the release of any medical and/or other information concerning me or my child obtained during this screening to and from the NJ Commission for the Blind and Visually Impaired, screening site, screening sponsor and involved health care providers with the understanding that such release is necessary for the delivery of Commission services and that all records will be treated as privileged and confidential information.

Signature:_____ _____ _____
Client, Parent, or Guardian's Signature Date Print Name if Parent or Guardian

NAME: **DOB:**

THIS SECTION IS FOR SCREENERS ONLY Screener's initials:_____ SITE:

Visual Acuity:	**O.D.**	**O.S.**	**Tonometry:**	**O.D.**	**O.S.**		**O.D.**	**O.S.**
Distance Vision without correction	20/	20/	Intraocular Pressure			Near Vision (if requested by doctor)		
Distance Vision with Present correction	20/	20/	If 22 or more take an additional reading:			(Children under 7 only) Muscle Imbalance (Y/N)		
Distance Vision with Pinhole (20/40 or Worse)	20/	20/						
☐ **Pass** ☐ **Fail** ☐ **Unable**			☐ **Pass** ☐ **Fail** ☐ **Unable**			☐ **Pass** ☐ **Fail** ☐ **Unable**		

Signature:_____ Signature:_____ Signature:_____

Screeners Comments:

Findings: ☐ **PASS (within screening guidelines)** ☐ Abnormal Visual Acuity ☐ Glaucoma Suspect ☐ Cataract ☐ Muscle Imbalance

☐ Diabetic Retinopathy ☐ Trauma ☐ other eye condition _____ ☐ Medical Referral ☐ Unable

Referral: ☐ No Referral ☐ Other Resources (for glasses) ☐ Other Resources (for evaluation) ☐ CBVI Services
☐ CBVI Fixed Site ☐ On-site doctor (for AVS) ☐ Private Eye Doctor ☐ Previous CBVI client
☐ Emergency room ☐ FQHC ☐ Self-Help / Support group

For VR Referral: Working ☐ **Yes** ☐ **No**, If yes - P/T ☐ or F/T ☐ , If No - Do you want to work? ☐ **Yes** ☐ **No**

Is change in Vision interfering doing your job? ☐ **Yes** ☐ **No** Do you need help to obtain a job? ☐ **Yes** ☐ **No**

Social Security #: _____ , ☐ **None**

Treatment Received: ☐ Yes ☐ No, if No, Reason _____

Source: ☐ CBVI Services ☐ CBVI Fixed Site ☐ On-Site Doctor ☐ Letter from Doctor ☐ Phone call ☐ Other