



Vision In Preschoolers Study Phase II

Gold Standard Exam

1. Identification

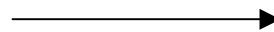
| | |
|---------------------|--------------------------|
| ID: ___ - ___ - ___ | DOB: ___ - ___ - ___ |
| | Day Month Year |
| Name: _____ | |

2. Color Square Test

a) Pretest

Able ()₁

Unable ()₀



Stop color test.
Go to Item 3

b) Finds **green** square 4 or 5 times

Yes ()₁

No ()₀

Incomplete ()₂

c) Finds **blue** square 4 or 5 times

Yes ()₁

No ()₀

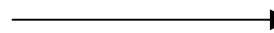
Incomplete ()₂

3. Visual Acuity - Binocular Pretest

Able ()₁

Unable - Training card ()₂

Unable - PC Monitor ()₃



| |
|---|
| 3a. Visual Acuity - OD |
| 20/ _____ |
| <input type="checkbox"/> ₁ ✓ if incomplete |
| 3b. Visual Acuity - OS |
| 20/ _____ |
| <input type="checkbox"/> ₁ ✓ if incomplete |

4. Determine if VA retest required.

No VA re-test required ()₀

VA re-test required ()₁

| |
|---|
| Coord Ctr Use Only: Initials ___ _ _ |
| Date: ___ - ___ - ___ |



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5. Stereo Smile

(Check 1 card only-the last card with 4 correct)

Unable to do Card A ()₀ (STOP!)

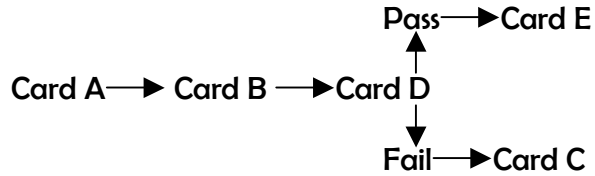
Card A ()₁

Card B ()₂

Card C ()₃

Card D ()₄

Card E ()₅



₁ ✓ if incomplete

6. Distance cover testing

Tropia (total deviation) ()₁

No tropia and no phoria ()₂

No tropia; phoria unknown ()₃

Can't determine ()₄

Phoria & no tropia ()₅

6A. Laterality ₁ ✓ if incomplete

Right ()₁

Left ()₂

Alternating ()₃

6B. Frequency ₁ ✓ if incomplete

Constant ()₁

Intermittent ()₂

6C. Direction (largest) ₁ ✓ if incomplete

Eso ()₁

Exo ()₂

Hyper ()₃

Hypo ()₄

6D. Magnitude ____ PD ₁ ✓ if incomplete
(Total Deviation)

6E. Direction (largest) ₁ ✓ if incomplete

Eso ()₁

Exo ()₂

Left Hyper ()₃

Right Hyper ()₄

6F. Magnitude ____ PD ₁ ✓ if incomplete
(Total Deviation)

ID: ____ - ____ - ____

Name: _____



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7. Near cover testing

- Tropia (total deviation) ()₁
- No tropia and no phoria ()₂
- No tropia; phoria unknown ()₃
- Can't determine ()₄
- Phoria & no tropia ()₅

7A. Laterality ₁ ✓ if incomplete

Right ()₁

Left ()₂

Alternating ()₃

7B. Frequency ₁ ✓ if incomplete

Constant ()₁

Intermittent ()₂

7C. Direction (largest) ₁ ✓ if incomplete

Eso ()₁

Exo ()₂

Hyper ()₃

Hypo ()₄

7D. Magnitude ____ PD ₁ ✓ if incomplete
(Total Deviation)

7E. Direction (largest) ₁ ✓ if incomplete

Eso ()₁

Exo ()₂

Left Hyper ()₃

Right Hyper ()₄

7F. Magnitude ____ PD ₁ ✓ if incomplete
(Total Deviation)

8. Versions

- No tropia in non-primary gaze ()₁
- Tropia in non-primary gaze ()₂
- Can't Determine ()₃

8A. Abnormalities (Comments):

8B. Ductions (Comments):

ID: ____ - ____ - ____

Name: _____



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9. Non-cycloplegic retinoscopy

Use zeros or dashes in each field [sphere, cyl, axis] for plano

| | OD | | OS |
|-------------------|---|--|---|
| | $+ / - \underline{\quad} . \underline{\quad} \underline{\quad}$ Circle Sphere | | $+ / - \underline{\quad} . \underline{\quad} \underline{\quad}$ Circle Sphere |
| | $+ / - \underline{\quad} . \underline{\quad} \underline{\quad} \times \underline{\quad}$ Circle Cyl Axis | | $+ / - \underline{\quad} . \underline{\quad} \underline{\quad} \times \underline{\quad}$ Circle Cyl Axis |
| OR | Can't Determine <input type="checkbox"/> ₁ | | Can't Determine <input type="checkbox"/> ₁ |
| WORK SPACE | <div style="text-align: center;"> 90° ———— 180° </div> | | <div style="text-align: center;"> 90° ———— 180° </div> |

10. Anterior segment

- Normal ()₁
- Abnormal ()₂
- Too shallow for drops ()₃
- Can't Determine ()₄

10A. Abnormal, Specify:

11. Drops

NOTE: Both sets of combination drops are REQUIRED!

- | Check if administered | OD | OS |
|--|--------------------------|--------------------------|
| a) ✓ Check if no drops administered | <input type="checkbox"/> | <input type="checkbox"/> |
| b) 0.5% proparacaine (Optional) | () ₁ | () ₁ |
| c) 1 st combination drop (Required) | () ₁ | () ₁ |
| d) 2 nd combination drop (Required) | () ₁ | () ₁ |

12. Time last drop:

____ : ____

ID: _____ - _____ - _____

Name: _____



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13. Cycloplegic retinoscopy

Use zeros or dashes in each field [sphere, cyl, axis] for plano

OD

+ / - . + / - . X
Circle Sphere **Circle** Cyl Axis

₁ ✓ if retinoscopy glasses refused

OS

+ / - . + / - . X
Circle Sphere **Circle** Cyl Axis

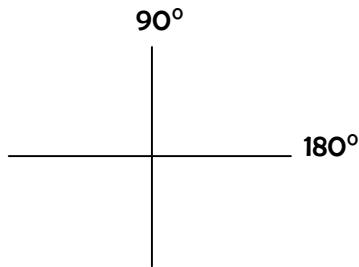
₁ ✓ if retinoscopy glasses refused

OR

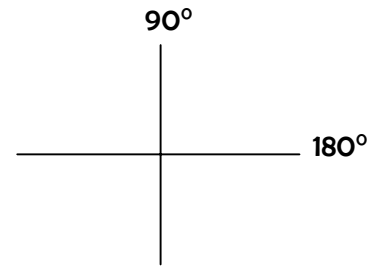
Can't Determine ₁

Can't Determine ₁

WORK SPACE



WORK SPACE



14. Is VA retest required?

No ()_o

Yes ()₁ _____



Test with full cycloplegic refraction in place

Test worse eye first. If no difference, test right eye first.

14a. Visual Acuity - OD
20/ _____
₁ ✓ if incomplete/unable

14b. Visual Acuity - OS
20/ _____
₁ ✓ if incomplete/unable

ID: _____ - _____ - _____

Name: _____



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VIP Form GE (302.5)
12/15/03
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NOTE: Detach this page ONLY from the rest of the form and keep it in the child's VIP folder. Do NOT return this page to the Coordinating Center. This page should be used as a reference to respond to parents' questions.

Examination findings

Spectacle correction

None **OR**

OD: + / - . + / - . X
Circle Sphere Circle Cyl Axis

OS: + / - . + / - . X
Circle Sphere Circle Cyl Axis

Referrals Made (if any)

Additional Notes

Signature

Date

| |
|--|
| ID: <u> </u> <u> </u> - <u> </u> <u> </u> - <u> </u> <u> </u> <u> </u> |
| Name: _____ |