Prevent Blindness Texas®

Adult Eye Health Screening Registration Form *(PLEASE PRINT)*

Screening Site Information (Screener Use Only)		
Date:	Site Location:	Participant ID:

SECTION 1: Participant Information			
First Name:		Last Name:	
Date of Birth: / /	Age:	Sex: ☐ M ☐ F	County:
Address:	City/State:		Zip Code:
Phone Number:		Email:	
Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native American ☐ Other:			
Number of People in Household:		Annual Household Income:	
Language Preference: ☐ English ☐ Spanish ☐ Other		Preferred Method of Contact: ☐ Phone ☐ Text ☐ Email	
1. Do you wear prescription glasses/contacts?		☐ Yes ☐ No	
a. If YES, do you have them with you?		☐ Yes ☐ No	
b. Do you wear them for (please check one):		☐ Distance ☐ Near/Reading ☐ Both	
2. Do you have a vision problem or eye disease?		☐ Yes ☐ No	
a. If YES, please describe:			

SECTION 2: Acknowledgment on Vision Screening (PLEASE SIGN BELOW)

Today's Adult Vision Screening can help determine if you see as well as you should. Keep in mind, however, that many underlying factors may affect the results of this vision screening. Also, a vision screening does not test for all eye disorders. A vision screening is not a substitute for a professional eye examination by an eye care professional. If you suspect that you are having any vision problems, you should arrange for a professional eye examination, regardless of today's screening results. I hereby authorize the disclosure of health information, related to the results of this screening and subsequent eye exam(s), to be shared with PBA/PBT for purposes related to follow up and statistical analysis. I am a resident of the State of Texas and I consent to a vision screening.

SIGN HERE:_____

SECTION 3: Risk Assessment	**Yes**	**No**	**Recommendations**
1. Do you have blood relatives with glaucoma?	☐	☐	☐ See doctor regularly
2. Has a doctor treated you for or said you have glaucoma?	☐	☐	☐ See doctor regularly
3. Have you had an eye injury or eye surgery?	☐	☐	☐ See doctor regularly
4. Have a noticed a change in your vision in the last 12 months?	☐	☐	☐ See doctor soon
5. Do you have persistent pain in or around the eye?	☐	☐	☐ See doctor now
6. Are you African American or Hispanic/Latino and over age 40?	☐	☐	☐ See doctor regularly
7. Are you age 65 or older?	☐	☐	☐ See doctor annually
8. Was your last dilated eye exam (with drops) more than two years ago?	☐	☐	☐ See doctor regularly
9. Do you have diabetes?	☐	☐	☐ See doctor annually
a. If yes, was your dilated eye exam (with drops) more than one year ago?	☐	☐	☐ See doctor soon
10. When was your last eye exam? ☐ Never ☐ Less than 1 year ☐ 1-2 years ☐ 3-5 years ☐ More than 5 years			
11. Do you have any barriers to receiving eye care (check all that apply)? ☐ Cost ☐ Fear of Doctors ☐ Fear of Treatment ☐ Lack of Transportation ☐ Clinic Waiting Time ☐ Lack of Knowledge ☐ Other:_____ ☐ None			

SECTION 4: Visual Acuity Screening (Screener Use Only)					
Distance	Right: 20/	Left: 20/	☐ Unable to Screen	☐ With ☐ Without Correction	Screener:
Near	Right: 20/	Left: 20/	☐ Unable to Screen	☐ With ☐ Without Correction	Screener:

SECTION 5: Exit Interview (Screener Use Only and Recommendations)

☐ PASS or ☐ REFER for: ☐ Risk Factors ☐ Visual Acuity (If 20/50 or worse in either eye, see doctor soon)

SECTION 6: Post-Screening Interview (Screener Use Only)

What type of insurance coverage do you have? ☐ Uninsured ☐ Medicaid ☐ Medicare ☐ County/City Health ☐ Private

Eye Exam Voucher Type:	☐ UH ☐ VSP ☐ Treatment Fund ☐ Other:_____ ☐ None
Eyeglass Voucher Type:	☐ Healthy Eyes ☐ VSP ☐ Treatment Fund ☐ Other:_____ ☐ None