



[Service provider logo]	Name of screener
	Date of screen
	Location

1. Information about the child	
Family name	Given names
Date of birth	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>
Address	
School	Class
Parent/caregiver details	
Family name	Given names
Phone/email	Languages spoken
Consent: Yes <input type="checkbox"/> No <input type="checkbox"/>	

2. Pre-screening questions		Result
<i>Copy the information from the completed consent form.</i>		
Does the child wear spectacles? Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes → What are the spectacles used for?	No → Continue Yes and a problem is identified during screening Refer to eye care personnel at service child is already using <input type="checkbox"/>
	Seeing things in the distance <input type="checkbox"/>	→ Ask child to wear spectacles for screening <input type="checkbox"/>
	Seeing things that are near <input type="checkbox"/>	→ Ask child not to wear spectacles for screening <input type="checkbox"/>
	Do not know <input type="checkbox"/>	
Does the child wear hearing aids? Yes <input type="checkbox"/> No <input type="checkbox"/>		No → Continue <input type="checkbox"/> Yes and a problem is identified during screening Refer to ear care personnel at service child is already using <input type="checkbox"/>
Does the child have diabetes? Yes <input type="checkbox"/> No <input type="checkbox"/>		No to both → Continue <input type="checkbox"/> Yes to either Refer to eye care personnel <input type="checkbox"/>
Pain / discomfort / severe itchiness in their child's eye/s. Yes <input type="checkbox"/> No <input type="checkbox"/>		
Concerns about child's vision? Yes <input type="checkbox"/> No <input type="checkbox"/>		No to both → Continue <input type="checkbox"/> Yes to either → Continue. If child passes arrange Follow up screen <input type="checkbox"/>
Concerns about child's hearing? Yes <input type="checkbox"/> No <input type="checkbox"/>		


3. Distance vision screen			
Chart:	8 years and younger <input type="checkbox"/> → HOTV Older than 8 years <input type="checkbox"/> → E chart		
Spectacles:	If the child wears spectacles for distance vision, are they wearing them today?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Right eye: Top line	Result	Right eye: Bottom line	Result
Child matches 2 or more letters correctly on the top line: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes → Continue bottom line No → Continue Left eye	Child matches 3 or more letters correctly on the bottom line: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes to both → Pass <input type="checkbox"/> No to any Refer <input type="checkbox"/>

Left eye: Top line	Result	Left eye: Bottom line	Result
Child matches 2 or more letters correctly on the top line: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes → Continue bottom line No → Continue Eye health screen	Child matches 3 or more letters correctly on the bottom line: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes to both → Pass <input type="checkbox"/> No to any → Refer <input type="checkbox"/>

4. Eye health screen <i>Look at each eye with torch.</i>			Result
Do both eyes look healthy? Yes <input type="checkbox"/> No <input type="checkbox"/>	No → Why?		Yes → Pass <input type="checkbox"/> No → Refer <input type="checkbox"/>
	Crust or pus on eyelids/eyelashes	<input type="checkbox"/>	
	Red colour on white of the eye	<input type="checkbox"/>	
	Discharge from eye	<input type="checkbox"/>	
	Coloured part of eye unclear/milky	<input type="checkbox"/>	
	Eyes not looking in the same direction	<input type="checkbox"/>	
	Other	<input type="checkbox"/>	

5. Hearing screen												
Practice screen								Result				
Does child hear sound at 1000Hz and 40dB?	Right ear: Yes <input type="checkbox"/> No <input type="checkbox"/>							Yes to both → Pass <input type="checkbox"/> No to any ➡ Refer <input type="checkbox"/> Stop hearing screen and → Continue to ear health screen.				
	Left ear: Yes <input type="checkbox"/> No <input type="checkbox"/>											
Full screen								Result				
	Tick if child hears 20 dB sound										Two or more ticks for each frequency for both ears → Pass <input type="checkbox"/> Less than two ticks for any frequency for either ear ➡ Refer <input type="checkbox"/>	
	1000 Hz				2000 Hz				4000 Hz			
Right ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Left ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

6. Ear health screen			
Outside of the ear <i>Look at each ear with eyes.</i>			Result
Do both ears look healthy? Yes <input type="checkbox"/> No <input type="checkbox"/>	No → Why?		Yes → Pass <input type="checkbox"/> No ↶ Refer <input type="checkbox"/>
	Damage / scars / injury	<input type="checkbox"/>	
	Pinna or ear canal missing, or very different shape	<input type="checkbox"/>	
	Swelling	<input type="checkbox"/>	
	Change of colour	<input type="checkbox"/>	
	Discharge	<input type="checkbox"/>	
Does the child feel pain when you press the tragus?	Left: Yes <input type="checkbox"/> No <input type="checkbox"/>		No to both → Pass <input type="checkbox"/> Yes to any → Stop the ear health screen and ↶ Refer <input type="checkbox"/>
	Right: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Inside the ear (ear canal and eardrum) <i>Check each ear with otoscope.</i>			Result
Do both ears look healthy? Yes <input type="checkbox"/> No <input type="checkbox"/>	No → Why?		Yes → Pass <input type="checkbox"/> No ↶ Refer <input type="checkbox"/>
	Pain	<input type="checkbox"/>	
	Swelling	<input type="checkbox"/>	
	Redness	<input type="checkbox"/>	
	Discharge	<input type="checkbox"/>	
	Blocked (wax or foreign body)	<input type="checkbox"/>	
	Damage / injury	<input type="checkbox"/>	
	Other	<input checked="" type="checkbox"/>	

Do both eardrums look healthy? Yes <input type="checkbox"/> No <input type="checkbox"/>	No → Why?		Yes → Pass <input type="checkbox"/> No  Refer <input type="checkbox"/>
	Unable to see eardrum	<input type="checkbox"/>	
	Swelling and/or redness on the eardrum	<input type="checkbox"/>	
	Holes (perforations)	<input type="checkbox"/>	

7. Plan		
Results	Plan	
Did not attend	Reschedule screening	<input type="checkbox"/>
Passed all results	Inform parents of results using Notification form	<input type="checkbox"/>
	Parent/caregiver has concerns	
	Discuss with parents	<input type="checkbox"/>
	Arrange follow up screen	<input type="checkbox"/>
Refer result for any: <ul style="list-style-type: none"> • Pre-screening questions • Vision screen • Eye health screen • Hearing screen • Ear health screen. 	Discuss need to refer with parents/caregivers	<input type="checkbox"/>
	Child already has spectacles or hearing aids	
	Ask parent/caregiver to take child to existing service provider	<input type="checkbox"/>
	Send Notification form	<input type="checkbox"/>
	Enter information into Follow up referral list	<input type="checkbox"/>
	Share information with screening coordinator	<input type="checkbox"/>