Mobile Unit Exam

Name:_____ **DOB:** _____ **Date of Exam:** _____

Referral/School: _____ **Name of Parent/Guardian:** _____

Address: _____ **Phone Number:** _____

Race/Ethnicity: _____ **AGE:** _____ **Gender:** _____

Pre-Mobile Unit Workup in School

Pink/Red Eye	Yes or No
Dilation Drop Used & Time	Turbo _____ or Cyclo _____
Pupillary Distance(PD)	Right Eye _____ Left Eye _____
Notes for Mobile Unit Staff	

Pre-Mobile Unit Visit Screening Exam Information

KEY: **OD=Right Eye** **OS=Left Eye** **OU=Both Eyes**

Plus Optix

Eye	Sph	Cyl	Axis	Notes
OD				
OS				

Visual Acuity

Eye	w/ Glasses	w/o Glasses	Near	Notes
OD				
OS				
OU				

EOMs (Extra Ocular Motility)

Eye	Findings		Notes
OD	Full/Normal	Abnormal	
OS	Full/Normal	Abnormal	

Glasses Option

Style	Color	Eye/Bridge/Temple Size

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Mobile Unit Work Up & Exam

Current Glasses Rx:

Eye	Sphere	Cylinder	Axis	ADD	Notes
OD					
OS					

Cycloplegic AR:

Eye	Sphere	Cylinder	Axis
OD			
OS			

Finalized Glasses Rx:

Eye	Date	Sph	Cyl	Axis	ADD	BCVA	Notes
OD							
OS							

Doctor Slit Lamp/Fundus Exam

Intraocular Pressure Exam

Date/Time	Method	OD		OS		Dilated?		Notes
	Tactile	Soft	Tense	Soft	Tense	YES	NO	

Slit Lamp Exam: _____

Fundus Exam: _____

Impression, Plan, & Follow-up

Diagnosis	Eye	Plan
1.	OD OS OU	Examined on mobile unit. No glasses rx needed. Finalized glasses rx. See Follow Up.
2.	OD OS OU	
3.	OD OS OU	
4.	OD OS OU	

Follow Up:_____

Scribe Signature:_____ **Date:**_____

Doctor Signature: **Date:**_____

Optical: 1 pair glasses received today /1 pair glasses to be ordered and delivered

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