



LIVINGSTON COUNTY DEPARTMENT OF PUBLIC HEALTH

2300 East Grand River Avenue, Suite 102 Howell, Michigan 48843-7578

www.lchd.org

ADMINISTRATION
517-546-9850
Fax: 517-546-6995

PERSONAL HEALTH
517-546-9850
Fax: 517-546-6995

ENVIRONMENTAL HEALTH
517-546-9858
Fax: 517-546-9853

VISION PROGRAM OPHTHALMOLOGIST/OPTOMETRIST REPORT

Early Childhood Early On Preschool School-age Wears Glasses/Contacts

Refer on: Vision Muscle 2-Line Difference + Lens History Other

Date: _____

Technician Initials: _____

Name: _____

Address: _____

Birthdate: _____

School: _____ Grade: _____

Important: Please have the Doctor complete this form and return to the Livingston County Department of Public Health. **Form may be faxed to LCDPH at 517-545-9685 (secure line)** or mailed to above address. Thank you.

DOCTOR'S REPORT:	Name: _____		Birthdate: _____	
	School: _____		Grade: _____	
VISION	Uncorrected	R / L /	o.u. /	
	Corrected	R / L /	if signif /	
DEFECT	<input type="checkbox"/> Myopia	<input type="checkbox"/> Hyperopia	<input type="checkbox"/> Astig.	<input type="checkbox"/> Muscle <input type="checkbox"/> Other <input type="checkbox"/> None
TREATMENT	<input type="checkbox"/> Glasses	<input type="checkbox"/> Exercises	<input type="checkbox"/> Medical	<input type="checkbox"/> Surgical
	<input type="checkbox"/> No RX at Present		<input type="checkbox"/> Not Necessary	
FURTHER TREATMENT RECOMMENDED			RETURN IN	
	<input type="checkbox"/> Medical	<input type="checkbox"/> Surgical	<input type="checkbox"/> Exercises	
	<input type="checkbox"/> Other	<input type="checkbox"/> None	_____ Weeks	_____ Months _____ Years
COMMENTS: _____				
SIGNED: _____ DEGREE: _____ DATE: _____				