NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

VISION DEFECT IN STROKE SCREENING TOOL

SMR060200

Identification of Vision Problems in patients with Stroke

Please complete pages 1 & 2 by direct communication with the patient/ their carer and/or observation of the patient & document findings in the Action column

Completed by: _____ Date: _____

QUESTION	Yes	No		ACTION
ASK if the patient:				
Have ever had their eyes tested?	☐	☐	**Yes**	**Date of last eye test:_____ with: _____**
Had an eye problem before the stroke? (*Such as: glaucoma, cataracts, macular degeneration or eye changes due to diabetes*)	☐	☐	**Yes**	**list known eye conditions:**
Routinely uses eye drops?	☐	☐	**Yes**	**List eye drops & use. Record in medical record:**
Wears glasses (*or contact lenses)*?	☐	☐	**Yes**	**Use appropriate glasses**
If so what for? *(tick one or both)*				
○ Near e.g. reading ☐				
○ Distance eg. driving/TV ☐				
Are glasses with the patient?	☐	☐	**No**	**Ask carer to bring glasses in**
Had any change in their vision since being admitted to hospital with this stroke?	☐	☐	**Yes**	**Refer for detailed eye examination**
Does your vision problem improve by wearing glasses?	☐	☐	**Yes** **No**	**Use appropriate glasses for activities** **Refer for detailed eye examination**
Do you have double vision?	☐	☐	**Yes**	**Refer for detailed eye examination**
Do you ever have sore, itchy, dry, watery, red or crusty eyes?	☐	☐	**Yes**	**Use appropriate eye drops. If this fails refer for eye examination**
OBSERVE for Droopy upper or lower eyelid	☐	☐		Refer for detailed eye examination if the answer is ***Yes*** for any observation **Note observation**
Shutting of an eye(s)	☐	☐		
Nystagmus (wobbling eyes)	☐	☐		
Patient misses seeing things or bumping into things	☐	☐		
CAN the patient without moving their head:				
Look at an object with both eyes at the same time	☐	☐		Refer for detailed eye examination if the answer is ***No*** for any action
Look from one object to another	☐	☐		
Follow an object smoothly from one side to the other	☐	☐		
Follow an object smoothly up and down	☐	☐		
CAN the patient see:				
Near Print – test over the page	☐	☐		Refer for detailed eye examination if the answer is ***No*** for either test
Distance Print – test over the page	☐	☐		
ACTIONS				☐ **No Action** ☐ **Eye Drops** ☐ **Glasses** ☐ **Onward Referral**

Name: _____ Designation: _____

Signature: _____ Date: _____/ _____/ _____

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

VISION DEFECT IN STROKE SCREENING TOOL

SMR060.200

NH700246 100217

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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

NEAR PRINT TEST

- **TEST IN GLASSES IF USUALLY WORN BY THE PATIENT**
- HOLD THE PAGE AT ELBOW LENGTH FROM THE PATIENT
- ASK THE PATIENT TO READ THE LETTERS BELOW AT ELBOW LENGTH FROM THE EYES

N E R X 1 4 3 5

DISTANCE PRINT TEST

- **TEST IN GLASSES IF USUALLY WORN BY THE PATIENT**
- HOLD THE PAGE AT 2 METRES FROM THE PATIENT
- ASK THE PATIENT TO READ THE LETTERS BELOW AT 2 METRES FROM THE PATIENT (if patient sitting in bed 2m is at end of bed)

A T O V 5 7 4 3

NO WRITING