



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

VISION DEFECT IN STROKE SCREENING TOOL

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

Name: _____ Designation: _____

Signature: _____ Date: ____/____/____



SMR060200

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH700246 100217



FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

D.O.B. ____/____/____

M.O.

Facility:

ADDRESS

VISION DEFECT IN STROKE SCREENING TOOL

LOCATION / WARD

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
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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
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Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING



SMR060200