OPTOMETRY CARES®
The AOA Foundation

InfantSEE Clinical Reporting Form

InfantSEE®

Current Year _____

InfantSEE Provider Information

O.D. Name: _____ _____

AOA I.D. Number: _____

O.D. State: _____ **O.D. Zip:** _____

Patient Information

Gender: ☐ M ☐ F

Race and Ethnicity: ☐ Hispanic or Latino Origin ☐ White ☐ Black/African American

☐ American Indian or Alaska Native ☐ Asian ☐ Other

How did parent find out about InfantSEE?

☐ Current Patient
☐ Friend/Family
☐ Mail
☐ TV
☐ Radio
☐ Internet
☐ Newspaper
☐ Primary Health Provider
☐ Parenting Classes
☐ Other, specify _____

Assessment Information

Ocular Motility	☐ No Concern	☐ Concern	☐ Problem _____
Binocularity	☐ No Concern	☐ Concern	☐ Problem _____
Refractive Status	☐ No Concern	☐ Concern	☐ Problem _____
Visual Acuity	☐ No Concern	☐ Concern	☐ Problem _____
Ocular Health	☐ No Concern	☐ Problem _____	

Please enter Clinical Reporting Form online at www.infantsee.org
or mail to: 243 N. Lindbergh Blvd., St. Louis, MO 63141
or fax to: 314.991.4101
For questions call: 314.983.4286 or email: InfantSEE@aoa.org