“An accurate understanding of the status of a child’s vision and hearing is necessary when determining his/her developmental status. Vision and hearing are integral to overall development. This provides information that assists in the assessment of a child’s developmental abilities in areas such as communication, cognition, gross/fine motor, social or emotional, and adaptive behavior. Further, vision and hearing screening help early intervention personnel and parents identify which children need additional assessment by professionals who specialize in these areas of development”. NM Family Infant Toddler Program, Technical Assistance Document, Evaluation and Assessment, February 2006.

The New Mexico FIT program requires that every child entering the Family Infant Toddler Program receive a vision screening. The New Mexico Vision Screening Tool was designed to help programs have a consistent method of screening vision for children in New Mexico. The screening tool includes parent interview as it is important to ask parents if they have noticed any vision problems.

1) Medical history is often related to vision problems and is included in the screening tool to help you think about medical history which might be related to vision issues. Exposures during pregnancy are included as certain exposures can also increase the possibility of vision problems. Family history is included because some vision issues in immediate family may be genetic.

2) Appearance of Eyes: sometimes visual problems can be noted by observation of the appearance of the eyes and this area indicates some of the observations that can be important.

3) Behaviors That Are Often Associated with Visual Impairment: Children often demonstrate behaviors which can indicate that they are having some difficulty with their vision. This checklist area is a reminder for the evaluator of some of these behaviors which can be related to vision problems.

4) Developmental Vision Screening: vision develops in a sequential, predictable sequence similar to other areas of development. This page is included to remind you of what typical visual skills you might expect for certain ages. Many of these items are related to your other developmental assessment tools.

5) The summary area of the vision screening tool is to discuss your observations about vision with the parent and to obtain permission to make a referral to NMSBVI for further vision assessment if needed.

Professional judgment within the team is a strong component of the decision-making process about whether to refer the child for further vision assessment. Because of the important role of vision in the early developmental sequence, NMSBVI would prefer “over” referrals to a “wait and see” approach.
NEW MEXICO VISION SCREENING TOOL
FAMILY INFANT TODDLER PROGRAM

(Adapted with permission from Baby Watch, Utah Early Intervention Program)
This screening does not equate with an assessment by a medical professional.

Child’s Name ____________________________ DOB ____________________________

Parent’s Name/Phone ____________________________
Chronological Age ____________________________ Adjusted Age ____________________________
Signature (person doing screening) ____________________________ Date ____________________________

Eye care Specialist ____________________________ Date of last exam ____________________________

PARENT INTERVIEW
Results of parent interview; describe any concerns: _______________________________________
_________________________________________________________________________________
_________________________________________________________________________________

I. HISTORY: (Check all that apply) __________ No Concerns

A. Child’s History

- Low birth weight < 3.5 lbs.
- Prematurity w/oxygen < 32 wks
- Small for gestational age
- Meningitis/encephalitis
- Head trauma/tumor
- Retinopathy of prematurity (ROP)
- Hydrocephaly/microcephaly
- Syndrome ___________.
- Cerebral hemorrhage
- Hypoxia, anoxia, low apgars
- Intraventricular hemorrhage (IVH)
- PVL (periventricular leukomalacia)
- Shaken Baby Syndrome
- Significant illness:
- Hearing loss
- Intraventricular hemorrhage (IVH)
- Seizures
- Sepsis
- Medications:
- Vacuum Extraction
- Cerebral Palsy

B. Exposures during pregnancy

- Rubella
- Toxoplasmosis
- Alcohol / drugs
- Cytomegalovirus (CMV)
- Significant Illnesses:
- Herpes
- Medication(s):

C. Immediate family history of childhood vision loss

- Strabismus/Amblyopia
- Retinal dystrophy / degeneration
- Systemic syndromes w/ ocular manifestations
- Congenital Cataracts
- Glasses in early childhood
- Retinoblastoma
- Congenital Glaucoma
- Sickle cell disease
- Other:

II. APPEARANCE OF THE EYE(S): (Check all that apply) __________ No Concerns

- Cloudy or milky appearance
- Keyhole pupil
- Sustained eye turn inward or outward? (after 4-6 months)
- Droopy eyelids
- Absence of eyes moving together
- Abnormal constriction or dilation of pupil (s)
- Difference between eyes (size, shape, etc.)
- Excessive tearing
- Jerky eye movements (nystagmus)

III. BEHAVIORS THAT ARE OFTEN ASSOCIATED WITH VISUAL IMPAIRMENT: __________ No Concerns

- Tilt or hold head in unusual position?
- Hold objects close to eyes or bend close to look?
- Seem to look beside, under, or above an object or person?
- Stare at lights, ceiling fans? (after 3 months of age)
- Visually inattentive/uninterested?
- Inconsistent visual behavior?
- High sensitivity to room light or sunlight?
- Difficulty sustaining eye contact?
### IV. DEVELOPMENTAL VISION SCREENING
(check each item observed)

#### BIRTH:
- **Yes** ☐ ☐ Responds to movement or light with a blink reflex
- **No** ☐ ☐ Pupil responds to light on/off
- **Comments**

#### BY 1 MONTH:
- **Yes** ☐ ☐ Turns head & eyes to light source
- **No** ☐ ☐ Regards face
- **Yes** ☐ ☐ Follows movement horizontally (either side of midline)
- **Comments**

#### BY 2 MONTHS:
- **Yes** ☐ ☐ Turns head to objects/lights on either side
- **No** ☐ ☐ Stares at objects or people
- **Yes** ☐ ☐ Smiles reflexively
- **Comments**

#### BY 3 MONTHS:
- **Yes** ☐ ☐ Follows object (tracks) 180 degrees
- **No** ☐ ☐ Regards own hands
- **Yes** ☐ ☐ Follows movement of people & objects
- **Comments**

#### BY 4 MONTHS:
- **Yes** ☐ ☐ Glances from one object to another
- **No** ☐ ☐ Uses vision to reach towards 1” object at 12”
- **Yes** ☐ ☐ Looks at 4” – 6” object at 3 feet
- **Comments**

#### BY 5 MONTHS:
- **Yes** ☐ ☐ Watches rolling tennis ball at 10 feet
- **No** ☐ ☐ Uses vision to reach directly to object
- **Yes** ☐ ☐ Over reaches ☐ Under reaches
- **Comments**

#### BY 6 MONTHS:
- **Yes** ☐ ☐ Watches rolling tennis ball at 10 feet
- **No** ☐ ☐ Uses vision to reach directly to object
- **Yes** ☐ ☐ Over reaches ☐ Under reaches
- **Comments**

#### BY 9 MONTHS:
- **Yes** ☐ ☐ Eyes converge on moving toy to within 4” of face
- **No** ☐ ☐ Watches activity of adults 15 – 20 feet
- **Comments**

#### BY 12 MONTHS:
- **Yes** ☐ ☐ Recognizes familiar object (bottle, toy) at 8-10’
- **No** ☐ ☐ Looks at pictures in a book
- **Comments**

#### BY 18 MONTHS:
- **Yes** ☐ ☐ Builds tower using 3 cubes
- **No** ☐ ☐ Looks at/picks up small object (raisin, cereal)
- **Comments**

#### BY 24 MONTHS:
- **Yes** ☐ ☐ Imitates facial and hand movements
- **No** ☐ ☐ Walks confidently in unfamiliar or varying surfaces
- **Comments**

#### VISUAL CONCERNS:
- **Yes** ☐ ☐
- **No** ☐ ☐
SUMMARY FORM

Child's Name: ________________________________ Birthdate: _________________________

Parent/Caregiver: ______________________________ Phone: _______________________

Parent’s Address: ______________________________________________________________

Referring Agency: _________________ Contact Person: ______________ Phone:_________

Date: ________________

SUMMARY

_________ We have no concerns regarding this child’s vision at this time; based on parent
interview, child/family medical history and developmental screening:

Caregiver signature: ______________________________    Date:_______________________

_________: We have identified risk factors/signs/observations, as noted in the vision screening.
I authorize you to release my child’s information to NMSBVI for follow-up. (If necessary, provide a
summary of concerns):

______________________________________________________________________________
______________________________________________________________________________

Caregiver signature: ____________________________ Date: ____________________________

REFERRAL INFORMATION

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Fax:  575-439-4448

Screening Tool adapted with permission of Baby Watch, Utah Early Intervention Program, by
New Mexico School for the Blind and Visually Impaired Infant Toddler Program