Dignity Health.
Chandler Regional Medical Center

PATIENT UNDERSTANDING AND CONSENT FOR VISION & HEARING SCREENING

Fill out information and sign consent for screening.

Call for an Appointment: 480-728-3140, Mon-Wed 9am-12pm please bring your consent form and a pen for personal use. Only the children needing screening and one adult will be permitted into the center. **If you, or anyone in your home, are sick with fever, cough, sore throat or shortness of breath, please delay your visit**

Full Name: ____ ☐Male ☐Female

Date of Birth: __________ Age: _____ Birth Hospital/State____________________ *(only 3yrs &under)*

Address: ____

City: __________________ Zip Code: _________ Phone Number: ____________________

E-mail Address____

Mother's Full Name: _____________________________ Date of birth _________

Health Insurance:
☐ None ☐ Kids Care
☐ AHCCCS ☐ Private
☐ Indian Health Services
☐ Underinsured*(Insurance doesn't cover cost)*
☐ Eligible for school lunch program

Child's Race: ☐ Hispanic ☐ White
☐ Black/African American ☐Asian
☐ American Indian ☐Alaskan Native
☐ Mixed Race

GENERAL INFORMATION: Chandler Regional Medical Center is committed to delivering compassionate, high-quality and affordable health care services. The Vision and Hearing Assessment Clinic will provide assessment and education by trained staff. (***Please note Hearing Screenings are available only up to 19 years of age***.) Students who are directly supervised by qualified staff may occasionally participate in clinic activities. The Vision and Hearing Assessment Clinic maintains current policies including, but not limited to, blood-borne pathogens and infectious diseases and safety. A copy of these policies is available on request.

CONSENT TO SCREENINGS: You will at all times have access to current and complete information about the results of you or your child's screening tests. At the Clinic, you or your child may receive one or more of the following: vision screening, hearing screening, and related education. **The Clinic will not provide any follow-up care to you or your child**. If you or your child needs follow-up care, we will provide a list of people who could provide that care. The person you choose may charge you for the care they provide. Before you or your child receives any screening you should ask about the screening and ask any questions you may have before you decide whether or not to give your consent for the screening to be done. We cannot promise that the screenings will help any condition you or your child may have. You have the right to be informed about the risks and benefits of the screenings we recommend. You have the right to consent to or refuse any proposed screening at any time prior to the screening.

MEDICAL RECORDS: The medical records are the property of Chandler Regional Medical Center. You have the right to look at and request a copy of you or your child's medical record. You may also ask to have your child's records sent to another health care provider by signing a Release of Information form. Chandler Regional Medical Center also complies with requirements of the Health Insurance Portability and Accountability Act (HIPAA) and you will receive separate information, forms and consents for HIPAA. **In addition, you or your child's medical record may be used to teach others and/or released to Vision 20/20 for data collection. If it is, you or your child's identity will not be disclosed to anyone who is not involved in your child's care and treatment.**

DISCONTINUANCE OF TREATMENT: The Clinic reserves the right to discontinue the screenings whenever the Clinic

believes it is in you or your child's best interest, or in the best interest of the Clinic program. If you have complaints, which cannot be resolved by people at the Clinic, please follow the grievance process.

SERVICES: Answer for the one receiving screenings today

History –

1. What services are you seeking today? ☐ ***Vision Screening*** ☐ ***Hearing Screening(0-18)***
2. a. Have you had a previous vision screening? ☐ No ☐ Yes

   b. Have you had a previous hearing screening? ☐ No ☐ Yes

3. Are there any ***concerns*** about vision and/or hearing?

   Vision____
   Hearing____

The computerized vision assessments are vision test. ***Vision Quest 20/20*** is a 2-3 minute computer game that may detect problems with you or your child's vision. ***SPOT*** is an auto refractor that screens you or your child's eyes at the same time. By measuring the light as it passes through the eyeball, it can detect vision issues quickly. Sometimes these screenings need to be repeated at a later date to get best results. If you or your child does not pass the screening, instructions will be given to you on what to do next.

The computerized hearing assessments: (This is for 0-18 years of age only) ***Otoacoustic Emissions (OAE's).*** During the ***OAE*** screening, a very small earpiece is placed in the outer part of the young child's ear. Soft tones and sounds are sent into the inner ear and a small computer measures the ear's response to sound and will let us know how well the inner part of your child's ear is working. ***Pure Tone*** uses headphones for older children. During the test, the child needs to sit quietly and raise each hand in response to the correct side. These hearing tests are very easy, takes only a few minutes, and won't hurt the child. Sometimes the test needs to be repeated to get best results. If your child does not pass the test, instructions will be given on what to do next. The information about your child may be shared with the Arizona Department of Health Services/Early Hearing Detection and Intervention Unit.

Your signature on this form certifies that you have read and understood the information provided on this form, that you have had the opportunity to ask questions that have been answered to your satisfaction and that you accept and give voluntary consent for the child to receive the services that you have marked below.

❑ **Vision Assessment**

❑ **Hearing Assessment (0-18)**

Date: __________________________ Print Name: ____

Signature: ____

If signed by other than the patient,
indicate relationship: parent or legal guardian: ____

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PATIENT UNDERSTANDING AND CONSENT FOR VISION & HEARING SCREENING

Staff Use Only:

Name: **DOB** **Age:**

Hearing Results

Right Ear ☐ Pass ☐ Fail ☐ Inconclusive

Left Ear ☐ Pass ☐ Fail ☐ Inconclusive

Right Ear	Pass	Refer	Left Ear	Pass	Refer
40dBHL/1000HZ			20dBHL/4000HZ		
20dBHL/1000HZ			20dBHL/2000HZ		
20dBHL/2000HZ			20dBHL/1000HZ		
20dBHL/4000HZ			25dBHL/500HZ		
25dBHL/500HZ					

Type of Test: ☐ OAE ☐ Pure Tone

ADHS report sent 0-3yrs - 1st time ☐ **2nd time** ☐

☐ Fax AZDHS

Results given: ☐ No problems found ☐ Inconclusive ☐ 1st time fail ☐ **2nd time fail**

☐ **Referral** –

☐ Hears for Kids ☐ Child's Insurance ☐ PCP Visit

Vision Results -VQ #____________________ **SPOT Results #**____________________________

VQ Results Screening: ☐ Pass ☐ Fail ☐ Pass Stereopsis

SPOT Results Screening: ☐ Pass ☐ Fail ☐ Inconclusive

Right Eye:	20/30 or better	20/32 or better	**Fail**
	20/35 or better	20/40 or better	
Left Eye:	20/30 or better	20/32 or better	**Fail**
	20/35 or better	20/40 or better	
Both Eyes:	20/30 or better	20/32 or better	**Fail**
	20/35 or better	20/40 or better	

SPOT Results: ☐ **6-17 months** ☐ **18-36 months**
☐ **3-8 years** ☐ **9-19 years** ☐ **20-40 years** ☐ **41-100 years**

☐ All Measurements Are in Range

☐ Inconclusive results ____________________

☐ **See Ophthalmologist**

Results of Concerns: ☐ **Gaze** ☐ **Amblyopia**
☐ **Myopia*(nearsighted)*** ☐ **Hyperopia*(farsighted)***
☐ **Astigmatism*(blurry)*** ☐ **Anisometropia**

SE:			**SE:**		
DS:	**DC:**	**Axis@**	**DS:**	**DC:**	**Axis@**

Results Given: ☐ No problems found ☐ Repeat Test ☐ See Ophthalmologist ☐ Age affected Results

Equipment Used: ☐**Vision Quest** ☐**SPOT** ☐**Inconclusive/Unable to Complete**

☐ **Referral** – **Vision Quest** ☐ **SPOT** ☐

☐ Target/glasses ☐ Insurance ☐ Americas Best ☐ Lions Club ☐ ____________________

Effective April 14, 2003, the law requires that Chandler Regional Medical Center give to a patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, the patient acknowledges receipt of such, or if you are the patient's personal representative, or authorized agent, or involved in patient's medical care, you acknowledge receipt of such.

Patient Name: ______________________________ Medical Record #: __________________

Acknowledgement Signature: ____________________________ Date: __________________

If not patient, print name: _________________________ Relationship to patient: ___________

For Official Use

I provided a copy of the NPP to the patient (or personal representative) but was unable to obtain his or her written acknowledgment of receipt of such for the following reasons:

____

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I have attempted to provide to the patient (or personal representative) a copy of the NPP, but was unable to do so for the following reasons:

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Signature of Hospital Representative: ___________________________ Date: _____________

NPP Version 4: June 1, 2010

Chandler Regional Medical Center

JOINT NOTICE OF PRIVACY PRACTICES FOR HEALTH INFORMATION (NPP) ACKNOWLEDGEMENT FORM

< Place Label Here >

ADM NPP

ADM NPP
(Rev. 08/05, 8/2/07, 6/1/10)