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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 1 of 11 · Basic information

### Basic information

Client name

Age

Sex

Select

Registration number (if enrolled)

Screening date

dd/mm/yyyy

Place of screening

Screening pathway

Select

Observe the person in a familiar environment and consult family members. Record Yes or No for each observation.

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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 2 of 11 · Vision · family

### Vision family history

1. Does anyone in the family have severe vision loss or eye disease? (e.g. albinism, amblyopia, cataracts, glaucoma, strabismus, retinoblastoma) ◯ Yes ◯ No

2. Did the mother have a serious infection or disease during pregnancy? (e.g. rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes) ◯ Yes ◯ No

3. Did the mother use drugs or alcohol during pregnancy? ◯ Yes ◯ No

4. Has a vision problem been identified or suspected? ◯ Yes ◯ No

5. Are there concerns about the child's vision? ◯ Yes ◯ No

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## Hearing & vision screening

Step 3 of 11 · Eye appearance

### Eye appearance

| | | |
|---|---|---|
| 1. Encrusted eyelashes | ○ Yes | ○ No |
| 2. Swollen or red eyelid | ○ Yes | ○ No |
| 3. Frequent styes | ○ Yes | ○ No |
| 4. Discharge in the eye or along the eyelids | ○ Yes | ○ No |
| 5. Concerns about the child's vision | ○ Yes | ○ No |
| 6. Eyes usually red or watery | ○ Yes | ○ No |
| 7. Pupils of different sizes or cloudy pupils | ○ Yes | ○ No |
| 8. Drooping eyelids | ○ Yes | ○ No |
| 9. Eyes do not appear straight (crossed eyes) | ○ Yes | ○ No |

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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 4 of 11 · Visual behaviour

### Visual behaviour

| | | |
|---|---|---|
| 1. Complains of aches or pain in the eyes | ○ Yes | ○ No |
| 2. Excessive headaches | ○ Yes | ○ No |
| 3. Dizziness or nausea after close eye work | ○ Yes | ○ No |
| 4. Squinting and constant blinking | ○ Yes | ○ No |
| 5. Frowning or facial distortion | ○ Yes | ○ No |
| 6. Constant rubbing of eyes or attempts to brush away a shadow | ○ Yes | ○ No |
| 7. Tilts head to see | ○ Yes | ○ No |
| 8. Closes or covers one eye when looking or reading | ○ Yes | ○ No |
| 9. Constantly asks someone to explain what is going on | ○ Yes | ○ No |
| 10. Poor eye-hand coordination, unusual clumsiness during hand tasks, or balance problems when walking | ○ Yes | ○ No |
| 11. Bumps into objects or is clumsy when walking, particularly in a new environment | ○ Yes | ○ No |
| 12. Unduly sensitive to bright light, glare or shiny objects | ○ Yes | ○ No |
| 13. Difficulty seeing at night or in the dark | ○ Yes | ○ No |
| 14. Needs glasses to see objects | ○ Yes | ○ No |

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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 5 of 11 · Vision outcome

### Vision screening outcome

Vision problem suspected

Select

Referred to ophthalmologist for clinical assessment

Select

Referred for functional vision assessment

Select

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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 6 of 11 · Hearing · family

### Hearing family history

1. Does anyone in the family have severe hearing loss or ear disease? (e.g. tinnitus, otitis media, perforated eardrum, Meniere's disease) ○ Yes ○ No

2. Did the mother have a serious infection or disease during pregnancy? (e.g. rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes) ○ Yes ○ No

3. Did the mother use drugs or alcohol during pregnancy? ○ Yes ○ No

4. Has a hearing problem been identified or suspected? ○ Yes ○ No

5. Are there concerns about the child's hearing? ○ Yes ○ No

Family hearing / ear disease details

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10. Screener opinion
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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 7 of 11 · Ear problems

### Ear problems

| | | |
|---|---|---|
| 1. Complaints of earache | ○ Yes | ○ No |
| 2. Complaints of headaches | ○ Yes | ○ No |
| 3. Complaints of ringing sounds or sensations in the ears, or hearing voices | ○ Yes | ○ No |
| 4. Recurring ear infections | ○ Yes | ○ No |
| 5. Frequent colds | ○ Yes | ○ No |
| 6. External ear or facial abnormality | ○ Yes | ○ No |

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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 8 of 11 · Hearing behaviour

### Hearing behaviour

| | | |
|---|---|---|
| 1. Turns one ear towards or away from the sound source | ○ Yes | ○ No |
| 2. Turns up the radio, television or headset | ○ Yes | ○ No |
| 3. Sits very close to the television or radio | ○ Yes | ○ No |
| 4. Appears to ignore conversation or instructions | ○ Yes | ○ No |
| 5. Seems engrossed in work, oblivious to surrounding sounds | ○ Yes | ○ No |
| 6. Constant humming, possibly to provide stimulation | ○ Yes | ○ No |
| 7. Startles at everyday sounds | ○ Yes | ○ No |
| 8. Relies excessively on gestures | ○ Yes | ○ No |
| 9. Poor spoken language | ○ Yes | ○ No |
| 10. Complains that others speak too loudly or too softly | ○ Yes | ○ No |
| 11. Cannot hear others from a distance or from behind | ○ Yes | ○ No |
| 12. Difficulty identifying familiar people by their voice | ○ Yes | ○ No |
| 13. Difficulty hearing speech with background noise | ○ Yes | ○ No |
| 14. Cannot hear when called from other nearby rooms at home or school | ○ Yes | ○ No |
| 15. Needs hearing aids to listen | ○ Yes | ○ No |
| 16. Problems with balance | ○ Yes | ○ No |

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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 9 of 11 · Hearing outcome

### Hearing screening outcome

Hearing problem suspected
Select

Referred to audiologist for audiometry
Select

Referred to ENT specialist for clinical assessment
Select

Referred for functional hearing assessment
Select

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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 10 of 11 · Screener opinion

### Opinion of the screener

Referral comment

Screener observations

Screener inference

Place

Screener signature

Choose File No file chosen

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## Hearing & vision screening

Step 11 of 11 · Review

### Review screening

Complete the preceding sections to review the enrolment details.

Screening outcomes and referral decisions are entered by the screener. No automatic clinical score is applied.

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Partner Coordinator

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## Screening review

Step 2 of 11 · Vision · family

**Screening review · proposed workflow**
Own organisation · submitted records

### Vision family history

1. Does anyone in the family have severe vision loss or eye disease? (e.g. albinism, amblyopia, cataracts, glaucoma, strabismus, retinoblastoma) ○ Yes ○ No

2. Did the mother have a serious infection or disease during pregnancy? (e.g. rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes) ○ Yes ○ No

3. Did the mother use drugs or alcohol during pregnancy? ○ Yes ○ No

4. Has a vision problem been identified or suspected? ○ Yes ○ No

5. Are there concerns about the child's vision? ○ Yes ○ No

Review comment

Return for correction

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Partner Administrator

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Beneficiaries / Screening / New draft

## Screening record

Step 2 of 11 · Vision · family

**Read-only survey view**
Own organisation · staff and caseload oversight

### Vision family history

| | | |
|---|---|---|
| 1. Does anyone in the family have severe vision loss or eye disease? (e.g. albinism, amblyopia, cataracts, glaucoma, strabismus, retinoblastoma) | ○ Yes | ○ No |
| 2. Did the mother have a serious infection or disease during pregnancy? (e.g. rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes) | ○ Yes | ○ No |
| 3. Did the mother use drugs or alcohol during pregnancy? | ○ Yes | ○ No |
| 4. Has a vision problem been identified or suspected? | ○ Yes | ○ No |
| 5. Are there concerns about the child's vision? | ○ Yes | ○ No |

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## Screening record

Step 2 of 11 · Vision · family

**Read-only survey view**
Programme oversight · identifiable access subject to permission

### Vision family history

1. Does anyone in the family have severe vision loss or eye disease? (e.g. albinism, amblyopia, cataracts, glaucoma, strabismus, retinoblastoma) ○ Yes ○ No

2. Did the mother have a serious infection or disease during pregnancy? (e.g. rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes) ○ Yes ○ No

3. Did the mother use drugs or alcohol during pregnancy? ○ Yes ○ No

4. Has a vision problem been identified or suspected? ○ Yes ○ No

5. Are there concerns about the child's vision? ○ Yes ○ No

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## Hearing & vision screening

Step 1 of 11 · Basic information

### Basic information

Client name

Age

Sex

Select

Registration number (if enrolled)

Screening date

dd/mm/yyyy

Place of screening

Screening pathway

Select

Observe the person in a familiar environment and consult family members. Record Yes or No for each observation.

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## Hearing & vision screening

Step 2 of 11 · Vision · family

### Vision family history

1. Does anyone in the family have severe vision loss or eye disease? (e.g. albinism, amblyopia, cataracts, glaucoma, strabismus, retinoblastoma)

◯ Yes ◯ No

2. Did the mother have a serious infection or disease during pregnancy? (e.g. rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes)

◯ Yes ◯ No

3. Did the mother use drugs or alcohol during pregnancy?

◯ Yes ◯ No

4. Has a vision problem been identified or suspected?

◯ Yes ◯ No

5. Are there concerns about the child's vision?

◯ Yes ◯ No

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## Hearing & vision screening

Step 3 of 11 · Eye appearance

### Eye appearance

1. Encrusted eyelashes
   - ◯ Yes ◯ No
2. Swollen or red eyelid
   - ◯ Yes ◯ No
3. Frequent styes
   - ◯ Yes ◯ No
4. Discharge in the eye or along the eyelids
   - ◯ Yes ◯ No
5. Concerns about the child's vision
   - ◯ Yes ◯ No
6. Eyes usually red or watery
   - ◯ Yes ◯ No
7. Pupils of different sizes or cloudy pupils
   - ◯ Yes ◯ No
8. Drooping eyelids
   - ◯ Yes ◯ No
9. Eyes do not appear straight (crossed eyes)
   - ◯ Yes ◯ No

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## Hearing & vision screening

Step 4 of 11 · Visual behaviour

### Visual behaviour

1. Complains of aches or pain in the eyes
   ◯ Yes ◯ No

2. Excessive headaches
   ◯ Yes ◯ No

3. Dizziness or nausea after close eye work
   ◯ Yes ◯ No

4. Squinting and constant blinking
   ◯ Yes ◯ No

5. Frowning or facial distortion
   ◯ Yes ◯ No

6. Constant rubbing of eyes or attempts to brush away a shadow
   ◯ Yes ◯ No

7. Tilts head to see
   ◯ Yes ◯ No

8. Closes or covers one eye when looking or reading
   ◯ Yes ◯ No

9. Constantly asks someone to explain what is going on
   ◯ Yes ◯ No

10. Poor eye-hand coordination, unusual clumsiness during hand tasks, or balance problems when walking
    ◯ Yes ◯ No

11. Bumps into objects or is clumsy when walking, particularly in a new environment
    ◯ Yes ◯ No

12. Unduly sensitive to bright light, glare or shiny objects
    ◯ Yes ◯ No

13. Difficulty seeing at night or in the dark
    ◯ Yes ◯ No

14. Needs glasses to see objects
    ◯ Yes ◯ No

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## Hearing & vision screening

Step 5 of 11 · Vision outcome

### Vision screening outcome

Vision problem suspected

Select

Referred to ophthalmologist for clinical assessment

Select

Referred for functional vision assessment

Select

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## Hearing & vision screening

Step 6 of 11 · Hearing · family

### Hearing family history

1. Does anyone in the family have severe hearing loss or ear disease? (e.g. tinnitus, otitis media, perforated eardrum, Meniere's disease)

◯ Yes ◯ No

2. Did the mother have a serious infection or disease during pregnancy? (e.g. rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes)

◯ Yes ◯ No

3. Did the mother use drugs or alcohol during pregnancy?

◯ Yes ◯ No

4. Has a hearing problem been identified or suspected?

◯ Yes ◯ No

5. Are there concerns about the child's hearing?

◯ Yes ◯ No

Family hearing / ear disease details

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## Hearing & vision screening

Step 7 of 11 · Ear problems

### Ear problems

1. Complaints of earache
   - ◯ Yes ◯ No
2. Complaints of headaches
   - ◯ Yes ◯ No
3. Complaints of ringing sounds or sensations in the ears, or hearing voices
   - ◯ Yes ◯ No
4. Recurring ear infections
   - ◯ Yes ◯ No
5. Frequent colds
   - ◯ Yes ◯ No
6. External ear or facial abnormality
   - ◯ Yes ◯ No

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Beneficiaries / Screening / New draft

## Hearing & vision screening

Step 8 of 11 · Hearing behaviour

### Hearing behaviour

1. Turns one ear towards or away from the sound source
   ◯ Yes ◯ No
2. Turns up the radio, television or headset
   ◯ Yes ◯ No
3. Sits very close to the television or radio
   ◯ Yes ◯ No
4. Appears to ignore conversation or instructions
   ◯ Yes ◯ No
5. Seems engrossed in work, oblivious to surrounding sounds
   ◯ Yes ◯ No
6. Constant humming, possibly to provide stimulation
   ◯ Yes ◯ No
7. Startles at everyday sounds
   ◯ Yes ◯ No
8. Relies excessively on gestures
   ◯ Yes ◯ No
9. Poor spoken language
   ◯ Yes ◯ No
10. Complains that others speak too loudly or too softly
    ◯ Yes ◯ No
11. Cannot hear others from a distance or from behind
    ◯ Yes ◯ No
12. Difficulty identifying familiar people by their voice
    ◯ Yes ◯ No
13. Difficulty hearing speech with background noise
    ◯ Yes ◯ No
14. Cannot hear when called from other nearby rooms at home or school
    ◯ Yes ◯ No
15. Needs hearing aids to listen
    ◯ Yes ◯ No
16. Problems with balance
    ◯ Yes ◯ No

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## Hearing & vision screening

Step 9 of 11 · Hearing outcome

### Hearing screening outcome

Hearing problem suspected

Select

Referred to audiologist for audiometry

Select

Referred to ENT specialist for clinical assessment

Select

Referred for functional hearing assessment

Select

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## Hearing & vision screening

Step 10 of 11 · Screener opinion

### Opinion of the screener

Referral comment

Screener observations

Screener inference

Place

Screener signature

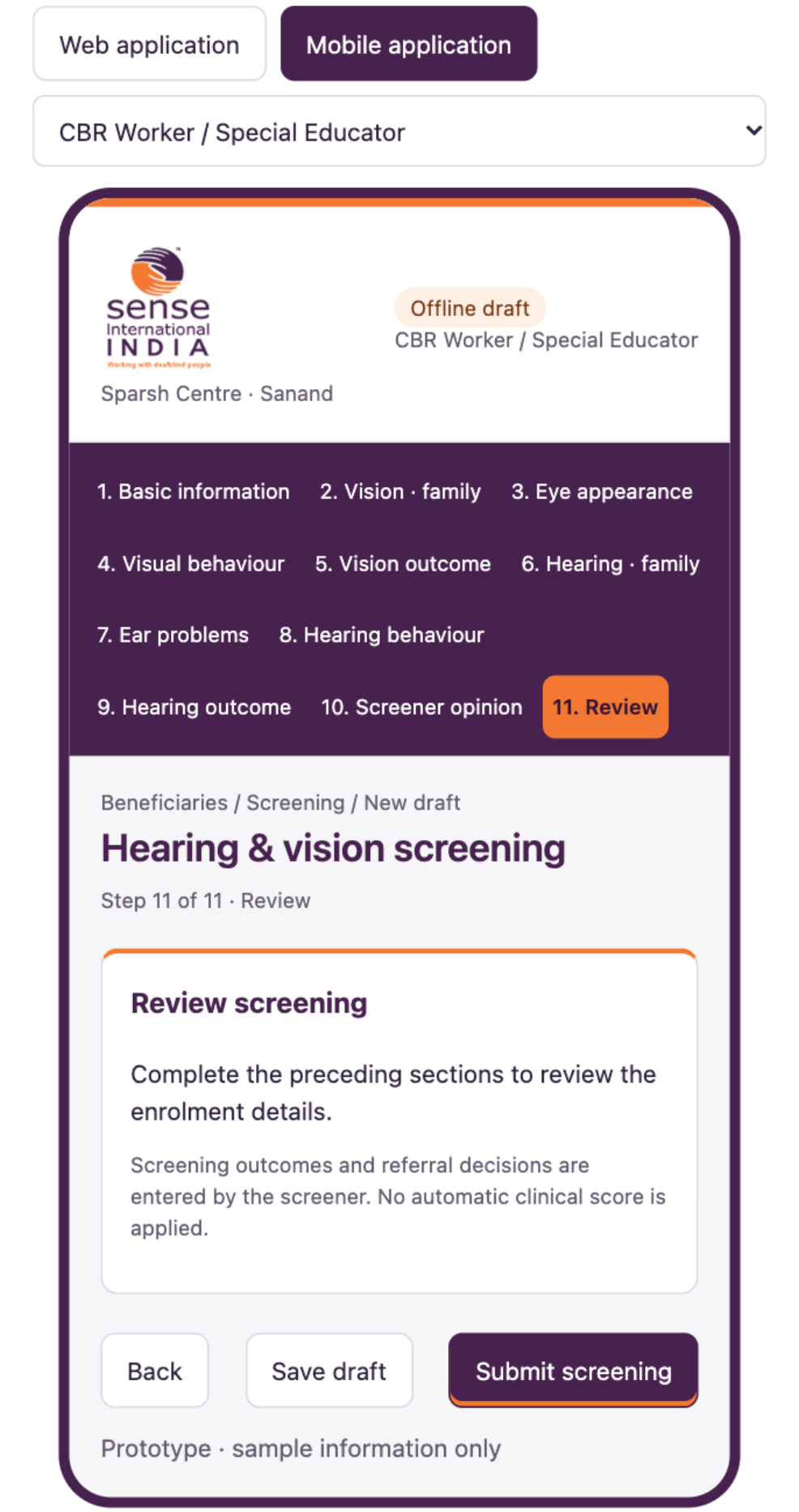
Choose File | No file chosen

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# Hearing and Vision Screening

Mobile | Step 11 of 11 - Review



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Partner Coordinator

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## Screening review

Step 2 of 11 · Vision · family

**Screening review · proposed workflow**

Own organisation · submitted records

### Vision family history

1. Does anyone in the family have severe vision loss or eye disease? (e.g. albinism, amblyopia, cataracts, glaucoma, strabismus, retinoblastoma)

○ Yes ○ No

2. Did the mother have a serious infection or disease during pregnancy? (e.g. rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes)

○ Yes ○ No

3. Did the mother use drugs or alcohol during pregnancy?

○ Yes ○ No

4. Has a vision problem been identified or suspected?

○ Yes ○ No

5. Are there concerns about the child's vision?

○ Yes ○ No

Review comment

Return for correction

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Web application | Mobile application

Partner Administrator

sense International INDIA
Working with deafblind people

Sparsh Centre · Sanand

Offline draft
Partner Administrator

1. Basic information | 2. Vision · family | 3. Eye appearance
4. Visual behaviour | 5. Vision outcome | 6. Hearing · family
7. Ear problems | 8. Hearing behaviour
9. Hearing outcome | 10. Screener opinion | 11. Review

Beneficiaries / Screening / New draft

## Screening record

Step 2 of 11 · Vision · family

**Read-only survey view**
Own organisation · staff and caseload oversight

### Vision family history

1. Does anyone in the family have severe vision loss or eye disease? (e.g. albinism, amblyopia, cataracts, glaucoma, strabismus, retinoblastoma)

Yes | No

2. Did the mother have a serious infection or disease during pregnancy? (e.g. rubella, cytomegalovirus, toxoplasmosis, syphilis, herpes)

Yes | No

3. Did the mother use drugs or alcohol during pregnancy?

Yes | No

4. Has a vision problem been identified or suspected?

Yes | No

5. Are there concerns about the child's vision?

Yes | No

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Prototype · sample information only

# Hearing and Vision Screening

Mobile | Sense India MEAL - role view

Web application | Mobile application

Sense India MEAL

sense International INDIA

Sparsh Centre · Sanand

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Sense India MEAL

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Beneficiaries / Screening / New draft

## Screening record

Step 2 of 11 · Vision · family

**Read-only survey view**

Programme oversight · identifiable access subject to permission

### Vision family history

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