Visual Difficulties Screening Protocol [Appendix 2: from SpLDs and Visual Difficulties a Guide for Assessors and SpLD practitioners]

**- with acknowledgement to Moody, Singleton and Jameson**

Questionnaire should ideally be completed prior to referral for SpLD assessment in order to allow time for visual difficulties to be assessed/addressed.

**Questions on eye and vision history**

1. When did you last have an eye test? (within 2 years is recent)
2. Was any prescription made (Yes/No)?

If YES, were you advised to wear your prescription for distance (e.g. television or driving) or near (e.g. reading) or both?

1. Do you wear your prescribed glasses/contact lenses (Yes/No)?

If NO, why not?

1. Do you have your glasses/contact lenses with you (Yes/No)?
2. Have you ever used coloured overlays/tinted glasses (Yes/No)?

If YES,

1. who advised and provided them?
2. why were they recommended?
3. did they help?

if YES, then in what way?

1. do you still use them?

**Questions on reading / near work activity**

1. How many hours reading per day, in a typical week?
2. How many hours on screen (phone, tablet or computer) per day, in a typical week?
3. By how much has your reading / near work time increased since you came to university?

**Any other comments/observations?**

**Visual symptoms questionnaire**20 questions addressing different aspects of visual difficulty as described previously. NB: high contrast pattern and fluorescent lamps may elicit visual disturbance and/or aversive responses in people with no particular visual problem or susceptibility – aspects of the normal response of the visual system to contrast and flicker – so questions about these are not considered indicative.

Visual difficulties should **ideally** be addressed prior to SpLD assessment. In making referrals based on the outcome of this screening questionnaire, assessors are advised that if **any** symptoms occur **often** or **always**, an optometrist referral is **always** recommended. Where symptoms occur only **sometimes** or less frequently, a referral could still be made but it should be made clear to the person being screened that the referral may not confirm any visual difficulty, and SpLD referral is not contra-indicated. Responses mainly **rarely** or **never** do not warrant onward referral.

For this protocol:

* Always = every day
* Often =  several times a week but not necessarily every day
* Sometimes = 2-3 times a month
* Rarely = only once every few months / a year

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
| 1 | Do you get headaches when you read? |  |  |  |  |  |
| 2 | Does reading make your eyes feel sore, gritty or watery? |  |  |  |  |  |
| 3 | Does reading make you feel tired or sleepy? |  |  |  |  |  |
| 4 | Do you become restless or fidgety or distracted when reading? |  |  |  |  |  |
| 5 | Do you become less comfortable the longer you read? |  |  |  |  |  |
| 6 | Do you prefer dim light to bright light for reading? |  |  |  |  |  |
| 7 | Does reading from white paper seem too bright or glaring? |  |  |  |  |  |
| 8 | Do parts of the white page between the words form patterns when you read? |  |  |  |  |  |
| 9 | Does the print or background shimmer or appear coloured as you read? |  |  |  |  |  |
| 10 | Does print appear to jitter or move on the page as you read? |  |  |  |  |  |
| 11 | Do you screw your eyes up when reading? |  |  |  |  |  |
| 12 | Do you rub your eyes to relieve the strain when you are reading? |  |  |  |  |  |
| 13 | Does text appear blurred, or go in and out of focus, when you read? |  |  |  |  |  |
| 14 | Do you move your eyes around or blink to keep text clear when you are reading? |  |  |  |  |  |
| 15 | Do objects in the distance appear more blurred after you have been reading? |  |  |  |  |  |
| 16 | Do you lose your place when reading? |  |  |  |  |  |
| 17 | Do you re-read or skip words or lines when reading? |  |  |  |  |  |
| 18 | Do you use a marker or your finger to stop you losing the place when you read? |  |  |  |  |  |
| 19 | Do you cover or close one eye when reading? |  |  |  |  |  |
| 20 | Do the words, page or book appear double when you are reading? |  |  |  |  |  |

**Referral decision:**