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| **Visual Difficulties Screening Protocol V.2. 2019: adults** |
| **Questions on eye and vision history** | **Comments and notes** |
| 1. Have you any history of visual difficulties / problems with sight / visual impairment?
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| 1. When did you last have a sight-test by an optometrist (“optician”)?
 |  |
| 1. Was any prescription made? **YES** / **NO**

If **YES**, were you advised to wear the prescription glasses/contact lenses for **distance** (e.g. for watching television or for driving) or **near** (e.g. for reading) or **both**?If **YES**, do you wear the prescribed glasses / contact lenses? **YES** / **NO**  If **NO**, why not? |  |
| 1. If **YES**, do you have the prescribed glasses/contact lenses with you today? **YES** / **NO**
 | Prescribed glasses/contact lenses should be worn for a SpLD assessment, unless intended for distance use only.  |
| 1. Have you ever used coloured overlays / colour-tinted glasses? **YES** / **NO**

 If **YES**,Who advised and provided them?Why were they recommended?Did they help? If **YES**, in what way?Do you still use them? If not, why not? |  |
| **Questions on reading / near work activity** |  |
| 1. Approximately how many hours per **working/study** day do you spend at a screen (phone, tablet, computer) etc?
 |  |
| 1. Approximately **how many additional hours** **per working /study** day do you spend reading books, newspapers, comics or other paper-based texts?
 |  |
| 1. Has your screen /reading /near work time increased recently? If so, by how much?
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|  | **Visual Difficulties Questionnaire (post - 16 years) \*** |
|  | **\*N.B. Response categories 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 | When do you prefer dim light to brighter 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 | Do you move your eyes around or blink to keep text clear when you are reading? |  |  |  |  |  |
| 14 | Do you use a marker or your finger to stop you losing the place when you read? |  |  |  |  |  |
| 15 | Do you cover or close one eye when reading? |  |  |  |  |  |
| 16 | Do you lose your place when reading? |  |  |  |  |  |
| 17 | Do you re-read or skip words or lines when reading? |  |  |  |  |  |
| 18 | Does text appear blurred, or go in and out of focus, when you read? |  |  |  |  |  |
| 19 | Do objects in the distance appear more blurred after you have been reading? |  |  |  |  |  |
| 20 | Do the words, page or book appear double when you are reading? |  |  |  |  |  |

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| **Visual Difficulties Screening Protocol V.2. 2019: children** |
| **Questions on eye and vision history** | **Comments and notes** |
| 1. Has your child any history of visual difficulties / problems with sight / visual impairment?
 |  |
| 1. When did you last have a sight-test by an optometrist (“optician”)?
 |  |
| 1. Was any prescription made? **YES** / **NO**

If **YES**, was your child advised to wear the prescription glasses/ contact lenses for **distance** (e.g. for watching television or for driving) or **near** (e.g. for reading) or **both**?If **YES**, does your childwear the prescribed glasses / contact lenses? **YES** / **NO**  If **NO**, why not? |  |
| 1. If **YES**, does your child have the prescribed glasses/contact lenses with them today? **YES** / **NO**
 | Prescribed glasses/contact lenses should be worn for a SpLD assessment, unless intended for distance use only.  |
| 1. Has your child ever used coloured overlays / colour-tinted glasses? **YES** / **NO**

 If **YES**,Who advised and provided them?Why were they recommended?Did they help? If **YES**, in what way?Does your child still use them? If not, why not? |  |
| **Questions on reading / near work activity** |  |
| 1. Approximately how many hours per school day does your child spend at a screen (phone, tablet, computer) etc?
 |  |
| 1. Approximately **how many additional hours** per school day does your child spend reading books, newspapers, comics or other paper-based texts?
 |  |
| 1. Has your child’s screen /reading /near work time increased recently? If so, by how much?
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|  | **Visual Difficulties Questionnaire (pre - 16 years) \*** |
|  | **\*N.B. Response categories 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** |
|  | **Section for parents/carers**  |  |  |  |  |  |
| 1 | Does your child report headaches when they are reading? |  |  |  |  |  |
| 2 | Does your child report that reading makes their eyes feel sore, gritty or watery? |  |  |  |  |  |
| 3 | Does your child report feeling tired or sleepy during or after reading? |  |  |  |  |  |
| 4 | Have you noticed your child become restless, fidgety or distracted when reading? |  |  |  |  |  |
| 5 | Have you noticed your child rubbing their eyes when they are reading? |  |  |  |  |  |
| 6 | Have you noticed your child screwing up their eyes when reading? |  |  |  |  |  |
| 7 | Have you noticed your child tilting their head to one side when reading? |  |  |  |  |  |
| 8 | Have you noticed your child moving their eyes around or blinking frequently when they are reading? |  |  |  |  |  |
| 9 | Have you noticed your child holding a paper or book very close to their eyes when reading? |  |  |  |  |  |
| 10 | How often does your child use a marker or their finger to keep their place when reading? |  |  |  |  |  |
| 11 | Have you noticed that your child frequently loses their place when reading? |  |  |  |  |  |
| 12 | Have you noticed your child covering or closing one eye when reading? |  |  |  |  |  |
|  | **Section for child** |  |  |  |  |  |
| 13 | When you read, do you see two of each word?  |  |  |  |  |  |
| 14 | When you read, do the words you read look blurry (or fuzzy, or unclear)?  |  |  |  |  |  |
| 15 | When you are reading, do the words move on the page?  |  |  |  |  |  |
| 16 | When your teachers ask you to copy something from a screen at the front of the classroom, can you see what is written on the screen? |  |  |  |  |  |