SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Reggio Emilia
IRCCS Istituto in tecnologie avanzate e modelli assistenziali in oncologia

To the parents of

IT'S IMPORTANT... TO SEE CLEARLY

SUBJECT: Call for orthoptic screening for early diagnosis of amblyopia (lazy eye)

Dear Parents,

We would like to invite your child for eye screening for early diagnosis of amblyopia on (date).....at (time)..... at (location).....

invitiamo il vostro bambino ad eseguire lo screening visivo per la diagnosi precoce dell'ambliopia il giorno.....alle ore..... presso.....

Amblyopia, commonly known as "lazy eye", is reduced vision in one eye which cannot be corrected by glasses or other optical aids, caused by abnormal visual development in the early years of life.

Amblyopia is the most common cause of childhood visual impairment, affecting 2-4% of children, and can become irreversible if not diagnosed in time for targeted treatments.

If amblyopia is diagnosed before 6 years old, it can be properly treated.

It is important to carry out an eye examination at 4 years old because children are not able to identify poor vision in one eye by themselves.

Orthoptic screening is an eye examination to diagnose and prevent amblyopia.

It is free and non-invasive, and lasts around 10 minutes. Screening is carried out by a Reggio Emilia Local Health Authority orthoptist.

Children who wear glasses will not be tested because the purpose of screening is to highlight unknown diseases. In this case, we ask that you return this form with your specialist's diagnosis.

CONTACTS

If you would like more information or if your child is receiving treatment for other eye problems, call 0522 335781 or write to screeningortottico@pec.ausl.re.it

To find out more (multilingual materials) www.ausl.re.it/screening-ortottico

PLEASE FILL IN THIS FORM

COMPILARE LA SCHEDA

1. Has your child already had an eye examination? YES ☐ NO ☐
   Il bambino ha già eseguito visita oculistica? SI NO

   (if YES, please attach the specialist's report. The orthoptist will assess whether your child should undergo screening based on any previous examinations).

   (se SI allegare referto specialistico. In base agli esami eseguiti l'ortottista valuterà se sottoporre comunque il bimbo allo screening).

2. Does your child have a patch over one eye? YES ☐ NO ☐
   Il bambino ha praticato l'occlusione (benda su un occhio)? SI NO

3. Are there any visual impairments in your family? YES ☐ NO ☐
   In famiglia sono presenti problemi visivi? SI NO

   (if YES, please specify the person and the type: long-sightedness, astigmatism, short-sightedness, squint)

   (Se SI specificare chi e di che tipo: miopia, ipermetropia, astigmatismo, strabismo)

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The undersigned Surname ____________________________ First Name ___________________________

Il/la sottoscritto/a Cognome ______________________________ Nome ________________________________

parent of the child Surname ___________________________ First Name ___________________________

genitore del minore Cognome _____________________________ Nome ________________________________

CONSENTS ☐ DOES NOT CONSENT ☐
AUTORIZZA NON AUTORIZZA

to the performance of the screening aimed at identifying any visual impairments.

all'esecuzione di test ai fini di uno screening volto all'individuazione di eventuali disturbi visivi.

Date ___ / ___ /______ Parent's signature _________________________________

Data ___ / ___ /______ Firma del genitore ____________________________________

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PLEASE RETURN THIS FORM TO THE SCHOOL