

# FAMILY INFANT TODDLER PROGRAM (FIT)

**NEW MEXICO VISION SCREENING TOOL  
FAMILY INFANT TODDLER PROGRAM  
NEW MEXICO SCHOOL FOR THE BLIND AND VISUALLY IMPAIRED (NMSBVI)  
505-271-3066  
Fax: 505-291-5456**

*“An accurate understanding of the status of a child’s vision and hearing is necessary when determining his/her developmental status. Vision and hearing are integral to overall development. This provides information that assists in the assessment of a child’s developmental abilities in areas such as communication, cognition, gross/fine motor, social or emotional, and adaptive behavior. Further, vision and hearing screening help early intervention personnel and parents identify which children need additional assessment by professionals who specialize in these areas of development”. ~ NM Family Infant Toddler Program, Technical Assistance Document, Evaluation and Assessment, February 2013.*

The New Mexico FIT program requires that every child entering the Family Infant Toddler Program receive a vision screening. The New Mexico Vision Screening Tool was designed to help programs have a consistent method of screening vision for children in New Mexico. The screening tool includes parent interview, as it is important to ask parents if they have noticed any vision problems.

- 1) Medical history is often related to vision problems and is included in the screening tool to help you think about medical history which might be related to vision issues. Exposures during pregnancy are included as certain exposures can also increase the possibility of vision problems. Family history is included because some vision issues in immediate family may be genetic.
- 2) Appearance of Eyes: Sometimes visual problems can be noted by observation of the appearance of the eyes and this area indicates some of the observations that can be important.
- 3) Behaviors That Are Often Associated with Visual Impairment: Children often demonstrate behaviors which can indicate that they are having some difficulty with their vision. This checklist area is a reminder for the evaluator of some of these behaviors which can be related to vision problems.
- 4) Developmental Vision Screening: Vision develops in a sequential, predictable sequence similar to other areas of development. This page is included to remind you of what typical visual skills you might expect for certain ages. With the exception of the “Birth” category, the items match the IDA Record (Infant-Toddler Developmental Assessment), 1995, which the State of New Mexico Family Infant Toddler Program has chosen for their state-wide developmental assessment to establish eligibility for Early Intervention Services.
- 5) The summary area of the vision screening tool is to discuss your observations about vision with the parent and to obtain permission to make a referral to NMSBVI for further vision assessment if needed.

Professional judgment within the team is a strong component of the decision-making process about whether to refer the child for further vision assessment. Because of the important role of vision in the early developmental sequence, NMSBVI would prefer “over” referrals to a “wait and see” approach. Please remember that if a family should decide that they do not want a referral, that the issue should be addressed again with the family at a future date for follow up.

## NEW MEXICO VISION SCREENING TOOL FAMILY INFANT TODDLER PROGRAM

(Adapted with permission from Baby Watch, Utah Early Intervention Program)

This screening does not equate with an assessment by a medical professional.

Referred to NMSBVI	<input type="checkbox"/>	Yes	<input type="checkbox"/>
No			
Date:			

Child’s Name \_\_\_\_\_ DOB \_\_\_\_\_

Parent’s Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

# FAMILY INFANT TODDLER PROGRAM (FIT)

Name (person doing screening) \_\_\_\_\_

Referring Agency \_\_\_\_\_

Contact Person \_\_\_\_\_

Phone \_\_\_\_\_

## PARENT INTERVIEW

Results of parent interview; describe any concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I. **HISTORY:** (Check all that apply)  **No Concerns**  **Unknown**

### A. Child's History

<input type="checkbox"/> Low birth weight < 3.5 lbs.	<input type="checkbox"/> Hydrocephaly/microcephaly	<input type="checkbox"/> PVL (periventricular leukomalacia)
<input type="checkbox"/> Prematurity < 32 wks	<input type="checkbox"/> Syndrome _____	<input type="checkbox"/> Non-accidental trauma (NAT)
<input type="checkbox"/> Small for gestational age	<input type="checkbox"/> Cerebral hemorrhage	<input type="checkbox"/> Significant illness:
<input type="checkbox"/> Meningitis/encephalitis	<input type="checkbox"/> Hypoxia, anoxia, low apgars	<input type="checkbox"/> Hearing loss <input type="checkbox"/> Medications:
<input type="checkbox"/> Head trauma/tumor	<input type="checkbox"/> Neurological disorder	<input type="checkbox"/> Sepsis <input type="checkbox"/> Seizures
<input type="checkbox"/> Retinopathy of prematurity (ROP)	<input type="checkbox"/> Intraventricular hemorrhage (IVH)	<input type="checkbox"/> Vacuum Extraction <input type="checkbox"/> Cerebral Palsy

### B. Exposures during pregnancy

<input type="checkbox"/> Rubella	<input type="checkbox"/> Toxoplasmosis	<input type="checkbox"/> Cytomegalovirus (CMV)	<input type="checkbox"/> Significant Illnesses:
<input type="checkbox"/> Herpes	<input type="checkbox"/> Alcohol / drugs	<input type="checkbox"/> Medication(s):	

### C. Immediate family history of childhood vision loss

<input type="checkbox"/> Strabismus/Amblyopia	<input type="checkbox"/> Retinal dystrophy / degeneration	<input type="checkbox"/> Systemic syndromes w/ ocular manifestations
<input type="checkbox"/> Congenital Cataracts	<input type="checkbox"/> Glasses in early childhood	<input type="checkbox"/> Retinoblastoma
<input type="checkbox"/> Congenital Glaucoma	<input type="checkbox"/> Sickle cell disease	<input type="checkbox"/> Other

II. **APPEARANCE OF THE EYE(S):** (Check all that apply)  **No Concerns**

<input type="checkbox"/> Cloudy or milky appearance	<input type="checkbox"/> Abnormal constriction or dilation of pupil (s)
<input type="checkbox"/> Irregular pupil shape	<input type="checkbox"/> Difference between eyes (size, shape, etc.)
<input type="checkbox"/> Sustained eye turn inward or outward? (after 4-6 months)	<input type="checkbox"/> Excessive tearing
<input type="checkbox"/> Droopy eyelids	<input type="checkbox"/> Jerky eye movements (nystagmus)
<input type="checkbox"/> Absence of eyes moving together	

III. **BEHAVIORS THAT ARE OFTEN ASSOCIATED WITH VISUAL IMPAIRMENT:**  **No Concerns**

<input type="checkbox"/> Tilt or hold head in unusual position?	<input type="checkbox"/> Visually inattentive/uninterested?
<input type="checkbox"/> Hold objects close to eyes or bend close to look?	<input type="checkbox"/> Inconsistent visual behavior?
<input type="checkbox"/> Seem to look beside, under, or above an object or person?	<input type="checkbox"/> High sensitivity to room light or sunlight?
<input type="checkbox"/> Stare at lights, ceiling fans? (after 3 months of age)	<input type="checkbox"/> Difficulty sustaining eye contact?

IV. **DEVELOPMENTAL VISION SCREENING** (check each item observed)

**Items match the IDA Developmental Profile Used by the New Mexico Infant Toddler Program (Except for the Birth Items)**

**FAMILY INFANT TODDLER PROGRAM (FIT)**

Yes	No	BIRTH:
<input type="checkbox"/>	<input type="checkbox"/>	Responds to movement or light with a blink reflex
<input type="checkbox"/>	<input type="checkbox"/>	Pupil responds to light on/off
<input type="checkbox"/>	<input type="checkbox"/>	Makes momentary eye contact
Comments		

Yes	No	BY 1-2 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Looks at object, follows visually
<input type="checkbox"/>	<input type="checkbox"/>	Looks at adult; responds to voice
<input type="checkbox"/>	<input type="checkbox"/>	Follows person with eyes
<input type="checkbox"/>	<input type="checkbox"/>	Observes movement in room
Comments		

Yes	No	BY 2-4 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Holds and looks at rattle
<input type="checkbox"/>	<input type="checkbox"/>	Social smile
<input type="checkbox"/>	<input type="checkbox"/>	Shows interest by reaching
<input type="checkbox"/>	<input type="checkbox"/>	Scans visual environment or turns away
Comments		

Yes	No	BY 4-7 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Reaches and grasps for toys
<input type="checkbox"/>	<input type="checkbox"/>	Retrieves lost pacifier or bottle
<input type="checkbox"/>	<input type="checkbox"/>	Initiates social contact
<input type="checkbox"/>	<input type="checkbox"/>	Facial mimic
<input type="checkbox"/>	<input type="checkbox"/>	Creates social contact (reaches)
Comments		

Yes	No	BY 7-10 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Works to obtain out of reach toy
<input type="checkbox"/>	<input type="checkbox"/>	Uncovers toy
<input type="checkbox"/>	<input type="checkbox"/>	Matches cubes
<input type="checkbox"/>	<input type="checkbox"/>	Reacts to strangers
<input type="checkbox"/>	<input type="checkbox"/>	Shows distinct stranger reaction
<input type="checkbox"/>	<input type="checkbox"/>	Plays peek-a-boo, pat-a-cake, so-big
Comments		

Yes	No	BY 10-13 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Tries to build a cube tower
<input type="checkbox"/>	<input type="checkbox"/>	Imitates scribble
<input type="checkbox"/>	<input type="checkbox"/>	Explores toys
<input type="checkbox"/>	<input type="checkbox"/>	Puts one object inside another
<input type="checkbox"/>	<input type="checkbox"/>	Finds toy behind solid screen
<input type="checkbox"/>	<input type="checkbox"/>	Uses object in imitation of an adult
<input type="checkbox"/>	<input type="checkbox"/>	Hands toy or other object back and forth
<input type="checkbox"/>	<input type="checkbox"/>	Rolls ball to another
<input type="checkbox"/>	<input type="checkbox"/>	Imitates actions
<input type="checkbox"/>	<input type="checkbox"/>	Uses locomotion to seek or avoid
Comments		

Yes	No	BY 13-18 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Walks well alone
<input type="checkbox"/>	<input type="checkbox"/>	Places pellet in bottle
<input type="checkbox"/>	<input type="checkbox"/>	Builds tower of two cubes
<input type="checkbox"/>	<input type="checkbox"/>	Builds tower of 3-4 cubes
<input type="checkbox"/>	<input type="checkbox"/>	Finds toy under cup
<input type="checkbox"/>	<input type="checkbox"/>	Explores drawers and cabinets
<input type="checkbox"/>	<input type="checkbox"/>	Indicates needs by pointing
<input type="checkbox"/>	<input type="checkbox"/>	Identifies one body part
<input type="checkbox"/>	<input type="checkbox"/>	Plays "Where is your eye?" etc.
<input type="checkbox"/>	<input type="checkbox"/>	Looks for hidden objects
<input type="checkbox"/>	<input type="checkbox"/>	Begins to detour around obstacles
<input type="checkbox"/>	<input type="checkbox"/>	Points or asks for desired object
Comments		

Yes	No	BY 18-24 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Walks upstairs, holding rail
<input type="checkbox"/>	<input type="checkbox"/>	Kicks large ball after demonstration
<input type="checkbox"/>	<input type="checkbox"/>	Runs well
<input type="checkbox"/>	<input type="checkbox"/>	Dumps pellets
<input type="checkbox"/>	<input type="checkbox"/>	Builds tower of 5 or 6 cubes
<input type="checkbox"/>	<input type="checkbox"/>	Places forms in formboard with help
<input type="checkbox"/>	<input type="checkbox"/>	Names one picture
<input type="checkbox"/>	<input type="checkbox"/>	Identifies 5 objects or pictures
<input type="checkbox"/>	<input type="checkbox"/>	Feeds self well with spoon
<input type="checkbox"/>	<input type="checkbox"/>	Imitates adult activities (use of tools, housekeeping, etc.)
Comments		

**FAMILY INFANT TODDLER PROGRAM (FIT)**

Yes	No	BY 24-30 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Walks upstairs, alternating feet
<input type="checkbox"/>	<input type="checkbox"/>	Builds tower of 9 cubes
<input type="checkbox"/>	<input type="checkbox"/>	Imitates vertical and horizontal strokes
<input type="checkbox"/>	<input type="checkbox"/>	Knows use of 3 objects
<input type="checkbox"/>	<input type="checkbox"/>	Uses objects in play to represent others
<input type="checkbox"/>	<input type="checkbox"/>	Places forms in formboard without help
<input type="checkbox"/>	<input type="checkbox"/>	Names 5 objects or pictures
<input type="checkbox"/>	<input type="checkbox"/>	Identifies 7 pictures
Comment		
s		
_____		
_____		
_____		

Yes	No	BY 30-36 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Strings small beads
<input type="checkbox"/>	<input type="checkbox"/>	Builds 3-cube structure
<input type="checkbox"/>	<input type="checkbox"/>	Imitates cross
<input type="checkbox"/>	<input type="checkbox"/>	Imitates 3-cube structure
<input type="checkbox"/>	<input type="checkbox"/>	Builds tower of 10 cubes
<input type="checkbox"/>	<input type="checkbox"/>	Copies circle
<input type="checkbox"/>	<input type="checkbox"/>	Solves formboard (rotates)
Comment		
s		
_____		
_____		
_____		

Yes	No	BY 36-42 MONTHS:
<input type="checkbox"/>	<input type="checkbox"/>	Cuts paper with scissors
<input type="checkbox"/>	<input type="checkbox"/>	Builds 3 cube structure from model
<input type="checkbox"/>	<input type="checkbox"/>	Names 10 pictures
Comment		
s		
_____		
_____		
_____		

**SUMMARY OF VISUAL CONCERNS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SUMMARY**

We have no concerns regarding this child's vision at this time; based on parent interview, child/family medical history and developmental screening.

We have identified risk factors or observations, as noted in the vision screening tool. Referral for consultation with NMSBVI:

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please complete separate release of information form.

Caregiver  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**RESUME**

A este tiempo no tenemos preocupaciones con respecto a la visión de su niño o niña; basado en la entrevista de padre; historia medica de niño o niña/familia y el examen del desarrollo.

Hemos identificado factores de riesgos u observaciones, como se a indicado en la herramienta del examen visual. Recomendación para una consulta con NMSBVI:

Si \_\_\_\_\_ No \_\_\_\_\_

En caso afirmativo, por favor de completar el formulario de información.

Firma de cuidador: \_\_\_\_\_

Fecha: \_\_\_\_\_

**REFERRAL INFORMATION**

New Mexico School for the Blind and Visually Impaired  
(NMSBVI) Infant Toddler Program  
**Phone:** 505-271-3066  
**Fax:** 505-291-5456

Screening Tool adapted with permission from Baby Watch, Utah Early Intervention Program, by New Mexico School for the Blind and Visually Impaired Infant Toddler Program