ACS Patient Outcome Form

Please visit us at allchildrensee.org/outcome for the electronic form, or scan the above QR code.

Doctor Name: First __________________________ Last _______________________

Patient Name: First __________________________ Last _______________________

☐ Mark if Patients First Visit    ☐ Mark if Follow-up Visit:
☐ Patient was seen
☐ Patient did not keep an appointment
☐ Patient did not schedule an appointment
☐ Patient was not seen

Diagnosis (check all that apply):
☐ Amblyopia
☐ Blocked Tear Duct
☐ Refractive Error
☐ Strabismus
☐ Anisometropia
☐ Chalazion
☐ No Disease
☐ Other:
    Specify: ____________

Which Treatment did you recommend (check all that apply):
☐ Surgery
☐ Patching/Atropine
☐ Subspecialty Referral
☐ Other:
    Specify: ____________
☐ Glasses
☐ Observation
☐ Other:
    Specify: ____________
☐ None

Estimate the cost of care you provided for the initial visit: ☐ Mark if Follow-up Visit:
☐ $0
☐ $200
☐ $1,000
☐ $100
☐ $250
☐ $2,000
☐ $150
☐ $500

Select any subsequent cost for the initial ACS patient visit: ☐ Mark if Follow-up Visit:
(e.g. surgeon’s fee, ongoing care for one year within the program):
☐ $0
☐ $200
☐ $1,000
☐ Eyeglasses
☐ $100
☐ $250
☐ $2,500
☐ Eye Patching
☐ $150
☐ $500
☐ $5,000
☐ As Needed