

# Answer sheet

Patient name: \_\_\_\_\_

NHS no: \_\_\_\_\_

5 Check eye movements	Actions
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There is no need for the patient to wear their glasses.  
The object of this check is to **see if the patient has double vision or difficulty looking to the side.**

Do you ever get double vision/see two of things?	Yes No
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Do the patient's eyes look straight?	Yes No
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Do the patient's eyes jiggle about/not keep still?	Yes No
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Do the patient's eyes move together to follow pen?	Yes No
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Does the patient complain of double vision during the test?	Yes No
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Next steps
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- > Document your concerns and immediate actions in the falls care plan.
- > Inform the medical team.

Date and time: \_\_\_\_\_

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

Print name: \_\_\_\_\_

Designation: \_\_\_\_\_