# SCREENING NEW PATIENTS. HEPS BASIC GUIDELINESS

- Technicians should always be courteous, smile and introduce themselves politely as escorting the Patients into the examining rooms. ***Remember! You are the first impression and it should always be professional.***

- Always verify Patient's name and date of birth as this is a new chart and we need to have accurate information in our EMR (Electronic Medical Records).

- Log into EMR with your personal password.

- Open the Patient's EMR and start the screening.

1. **Chief Complaint:** Why is patient here? Usually a sentence in Patient's own words.
2. **History of Present Illness: What** Symptoms? **Where**? **Severity**? **When**? (Timing, frequency and duration. Use "length of time" - don't use the days of the week but "for the past 3 days"). **Modifying factors** and **associated signs and symptoms**. (If headaches, when, how bad, how long, effect on vision, other symptoms, gets nauseous? Keep from sleep? Awaken with headache? Rate pain on a scale of 1 to 10. If floaters, ask about flashes of light and vision changes). **Last eye exam.** Also ask if this is regular check-up, or is patient interested in contact lenses. **Referred by**, **PCP**, is Patient oriented? Do they need translation? Etc...
3. **Past History and review of systems:** Head, Heart, Lungs, GI, GU, Nervous system, Extremities. HBP, Heart Disease, Diabetes (and for how long? On insulin? Last BS? Hemoglobin A1C? ) Stomach problems, arthritis, lupus, prostate medications…
4. **Current Medications:** names, doses if possible. Include OTC meds. Try to match every medication with a corresponding diagnosis.
5. **Allergies:** Drug allergies, Hay fever, latex.
6. **Past Ocular History:** Prior eye problems, surgeries, glaucoma, cataracts, keratoconus, retina problems, corneal problems. Do they wear contact lenses? Soft? Hard, Daily Wear, Extended Wear, Disposable, Solutions, use of Enzymes.
7. **Ocular Medications:** Drops, name and dosage. When was last drop used?
8. **Social History:** Drugs?, ETOH?, Smoking?
9. **Family history:** Any medical condition in maternal/paternal side. Always ask about glaucoma, diabetes, high blood pressure.
10. **Measure glasses**
11. Document current contact lens parameters if known
12. Be sure to ask patient if they want contacts or to be fit for contact lenses, explain charges for fit. ***$100 for I&R or $50 for only a fit.***

**Exam**

1. **Vision:** (with "best pair" of glasses if wears) (need to note if **CC, SC, CL or IOL**) distance and near. If pt states sees better **sc**, do both **cc** and **sc. If vision is not 20/20 do PH unless refraction is 20/20.**
2. Gross **color** test (red, green, yellow, etc): If abnormal-do Ishihara color plates.
3. **Confrontation** Visual Field.
4. **Amsler** if appropriate. For instance: Red -Long term use of plaquenil and white -ARMD.
5. **Auto K/ Auto ref.**

6. **Manual Keratometry Reading**: For difficult refractions, when Patients are interested in cataract surgery and when unable to do Auto K.
7. **Refraction:** Manifest all prior to dilation, Add for presbyopic patients and single vision IOL. Include near vision in manifest refractions. (Ask patients if they were informed about refraction fee, up to $50)
8. **Gross motility** (If abnormal, do not dilate).
9. **Check pupils** (If abnormal, do not dilate)
10. **Slit lamp exam**: look at anterior chamber depth and for obvious abnormalities – if shallow chamber or any abnormality with pupils do not dilate.
11. **IOP:** applanation is preferred method, if in doubt should ask the doctor before instilling flourescein. Don't do IOP if there is any anterior issue such corneal abrasion/ulcer, dryness, redness, uveitis and if patient was referred for a corneal consult. (**Don't do IOP for DJC**) (Only do IOP if vision is improved to 20/20 and there are no complaints or evidence of dryness, redness, allergies, inflammation, uveitis, etc.)
12. **Dilate:** If patient is under 40, (check to see if hyperopic, if so, be sure you refracted if necessary, recording near vision), then dilate. **Don't dilate for DJC.** (Do not dilate If questionable refraction, pupils, motility or neurological symptoms).

**End of Exam**

1. Record all the findings/discussions accurately (If in doubt, ask the doctor immediately)

2. On the chart when indicating to **R.T.O** for next office visit, note the length of the appointment (Brief, Complete, testing), and what is to be done at that visit (dilation – can it be done immediately and with what drops, VF, Photos, etc)

3. Be sure Route sheet template is filled out including all codes and PQRI if appropriate. Be sure any testing and procedure is entered, ask the doctor if questions.

4. Prescriptions printed and signed.

5. Log out of EMR

6. Escort the Patient out of the rooms into the front desk.

# NEW PATIENT COMPLETE EXAM

1 **Chief Complaint:** Why is patient here? Last eye exam? Contact lenses? Referred by? **PCP**? VSP patient – ask about desire for contacts.
2 **History of Present Illness:** What? Where? Severity? When? Duration?
3 **Past Medical History:** Head, Heart, Lungs, GI, GU, Nervous system, Extremities. If diabetic: Last BS? Hemoglobin A1C? Prostate medications?
4 **Current Medications:** names, doses if possible.
5 **Review of Systems:** See #3 above.
6 **Allergies:** Drug allergies, Hay fever
7 **Past Ocular History:** Prior eye problems, surgeries, glaucoma, cataracts, keratoconus, retina problems, corneal problems. Do they wear contact lenses? Soft? Hard, Daily Wear, Extended Wear, Disposable, Solutions, use of Enzymes.
8 **Ocular Medications:** Drops, name and dosage. When was last drop used?
9 **Social History:** Drugs? ETOH? Smoking?
10 **Family history:** Any medical condition in maternal/paternal side. Always ask about glaucoma, diabetes, high blood pressure.
11 **Measure current glasses**
12 Document current **contact lens parameters** if known.
13 Be sure to ask patient if they want contacts or to be fit for contact lenses, explain charges for fit. ***$100 I & R or $50 only fit***

**Exam**

1 **Vision:** (“best pair” of glasses if wears) (need to note if **CC, SC, CL or IOL**) distance and near. If pt states sees better **sc**, do both **cc** and **sc. If vision is not 20/20 do PH unless refraction is 20/20.**
2 Gross **color** test (red, green, yellow, etc): If abnormal-do Ishihara color plates.
3 **Confrontation Visual Field**
4 **Amsler** if appropriate. See exam #3 above. (Lupus-use of plaquenil, ARMD, etc.)
5 **Auto Ref/Auto K.**
6 **Keratometry** (if appropriate)
7 **Refraction:** Manifest all prior to dilation. Add and near vision in manifest refractions. (Ask patients if they were informed about refraction fee, up to $50)
8 **Gross motility** (If abnormal, do not dilate).
9 **Check pupils** (If abnormal, do not dilate)
10 **Slit lamp exam**, look at anterior chamber depth and for obvious abnormalities – if shallow chamber or any abnormalities with pupils or iris do not dilate.
11 **IOP:** applanation is preferred method, if in doubt should ask the doctor before instilling flourescein. Don’t do IOP if there is any anterior issue such corneal abrasion/ulcer, dryness, redness, uveitis and if patient was referred for a corneal consult. (**Don’t do IOP for DJC**) (For other doctors only do IOP if vision is improved to 20/20 or best prior correction and there are no complaints/evidence of dryness, redness, allergies, inflammation, uveitis, etc.)
12 **Dilate:** If patient is under 40, (check to see if hyperopic, if so, be sure you refracted if necessary, recording near vision), then dilate. **Don’t dilate for DJC.**
(Do not dilate If questionable refraction, pupils, motility or neurological symptoms).

# ESTABLISHED PATIENT COMPLETE EXAM

ALWAYS CHECK THE LAST DISCUSSION FOR ANY TESTING NEEDED ***SPECIAL ATTENTION TO GLAUCOMA PATIENTS WHO MUST HAVE VF, OCT AND GONIO ANNUALLY*** AND ALSO TO VERIFY THAT PATIENT IS ACTUALLY A COMPLETE EXAM!

1. **Chief Complaint:** Same as above
2. **History of Present Illness:** Same as above
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of). Head, Heart, Lungs, GI, GU, Nervous system, Extremities. If diabetic: Last BS? Hemoglobin A1C?
4. **Current Medications:** Review Patient's medications **one by one**. Inactivate medications approximately when stopped.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Ask if patient has been to another eye care practitioner since being at HEPS. Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications:** REVIEW with patient the eye medications they are using, name and dosage. When was last drop used?
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.
11. **Measure glasses:** If glasses bought from Rx elsewhere

**Exam**

1. **Vision** (with glasses if wears) (need to note if cc, sc, CL or IOL) distance and near
2. Gross **color test** (red, green, etc) or plates whenever necessary and for all VSP.
3. **Confrontation Visual Field** as needed and for all VSP.
4. **Amsler** if appropriate.
5. **Auto Ref/Auto K:** If there is a change in vision or if the Patient had recent eye surgery somewhere else.
6. **Keratometry**: if patient wants contacts and we don't have K readings in chart.
7. **Refraction for all VSP patients, when there are vision changes, when the patient complains of blurred vision or wants new glasses.** (Ask patients if they were informed about refraction fee, up to $50)
8. **Gross motility** (If abnormal, do not dilate).
9. **Check pupils** (If abnormal, do not dilate)
10. **Slit lamp exam**, look at anterior chamber depth and for obvious abnormalities – if shallow chamber or any abnormalities with pupils or iris do not dilate.
11. **IOP:** applanation is preferred method, if in doubt; you should ask the doctor before instilling flourescein. (**Don't do IOP for DJC** unless vision is 20/20 and patient is under 25 with no known medical conditions) (All other doctors only do IOP if vision is improved to 20/20 or best prior correction and there are no complaints/evidence of dryness, redness, allergies, inflammation, uveitis, etc.)
12. **Dilate:** If patient is under 40 (Do not dilate if questionable refraction, pupils, motility or neurological symptoms, ASK). **Don't dilate for DJC** unless vision is 20/20 and patient is under 25 with no known medical conditions.
13. **Record/anticipate any extra testing needed before the R/C such as Cycloplegic refractions, OCT's, K&A, etc. If in doubt ask!**

# IOP CHECK / BRIEF CHECK

**FOR GLAUCOMA PATIENTS: ALWAYS CHECK** date of last dilation/OCT, visual field, optic nerve photos & gonioscopy.

1. **Chief Complaint:** Any complaints? Pain, vision changes.
2. **History of Present Illness:** Same as above.
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. **Vision**: (with glasses if wears) (need to note if cc, sc, CL or IOL) distance and near. **PH as needed** if the vision has decreased.
2. **Refraction: Only when there are vision changes, when the patient complains of blurred vision or wants new glasses.** (Ask patients if they were informed about refraction fee, up to $50) Always include near vision.
3. **Check pupils**
4. **Slit lamp exam**, look at anterior chamber depth and for obvious abnormalities – if shallow chamber or any abnormalities with pupils or iris do not dilate.
5. **IOP for all doctors except DJC:** applanation is preferred method, if in doubt; you should ask the doctor before instilling flourescein. For DJC can do IOP if Patient is under 40 and no glaucoma. (Only do IOP if vision is stable and there are no complaints/evidence of dryness, redness, allergies, inflammation, uveitis, etc.)

**End of Exam**

1. Prescriptions recorded/updated in EMR, ERx'd or printed.

2. Be sure check-off form is filled out, show doctor, if question (Diagnosis (medical and visual and Procedure(s)

3. Follow up appt indicated (any need to block slots? Specialty testing indicated?) Can patient be dilated, with what, immediately, need refraction, etc.

4. Log out of EMR

# 1 DAY POST CATARACT SURGERY

1. **Chief Complaint:** Enter "Post-Op visit for surgery on xx/xx/xx – type of surgery, OD/OS" Any complaints? Pain, vision changes, questions?
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications:** ***REVIEW*** with patient the eye medications they are using, name and dosage. When was last drop used? Ask if they were given the post op Kit. Dr. WHC's Patients usually have the kit **given after surgery** If the patient did not get the kit the technician will provide one with written instructions. **Steroid QID, Antibiotic QID and NSAID** (if appropriate, check) QID, TID or BID. Review how to use the drops. In addition, Patients need to use the shield at bedtime at least for 3 nights to protect the eye while sleeping. ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. If the Patient comes to office wearing the patch, the technician will carefully remove the patch saving the protective shield and cleaning gently the area around the eye until the patient can easily open it.
2. **Vision**: Always be aware of the last discussion to know if you are expecting a vision improvement or not. Check distance vision **SC** in the operated eye and best corrected for the non operated eye. **PH for the operated eye** if needed. Also be aware of type of IOL. ***Do not check near vision for crystalens***! And most of the Patients will still be dilated so near vision will not be optimal.

***NOTE:***

a. ***For Dr. DJC's Patient's*** *instill a drop of the antibiotic, record it in EMR and leave the kit ready for him to instill the steroid drop before the Patient leaves the office.*
b. ***For Dr. WHC, SW and BAM TECHNICIAN CAN DO IOP*** *unless slit lamp exam is not within the normal post op (Sub-conj heme, injection), the technician doesn't feel comfortable with performing the test or there is any objection from the Patient.*
c. ***For JDP do not do IOP on 1 day post op.***

**End of Exam**

1. Route sheet should indicate PO visit.

2. Patient should be aware of mild fluctuation in vision during healing process.

3. Follow up should be 5-7 days for K&R of the operated eye unless indicated differently. (Only PO visit without K&R for DJC)

4. Log out of EMR

# 1 WEEK POST CATARACT SURGERY

1. **Chief Complaint:** Any complaints? Pain, vision changes, questions?
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications:** ***REVIEW*** with patient the eye medications they are using, name and dosage. When was last drop used? ALWAYS update the eye medications in EMR, indicating dosage. They may have finished the antibiotic and NSAID but they should still be on steroid QID!
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. **Vision**: Check distance vision **SC** in the operated eye and best corrected for the non operated eye. **PH for the operated eye** if no improvement from the previous visit. Also be aware of type of IOL. ***Do not check near vision for crystalens!***
2. **Auto K/ Auto ref in the operated eye**
3. **Manual Keratometry Reading in the operated eye**: For difficult refractions and when unable to do Auto K.
4. **Refraction:** Manifest for the operated eye with add as needed (Unless it's a multifocal IOL or crystalens). Always include near vision.
5. **IOP for WHC, SW, JDP and BAM. (If no complaints/ red eye)**
6. **Check pupils.**

***NOTE:***

*a. **For Dr. DJC's Patient's** only do auto K/Auto ref if vision is not better. You don't have to do refraction at this point and **DO NOT DO IOP.***

**End of Exam**

1. Route sheet should indicate PO visit.

2. Follow up should be 10-15 days for final K&R unless indicated differently.

3. Log out of EMR

# 3 WEEKS POST CATARACT SURGERY

1. **Chief Complaint:** Any complaints? Pain, vision changes, questions?
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one.**
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications:** ***REVIEW*** with patient the eye medications they are using, name and dosage. When was last drop used? ALWAYS update the eye medications in EMR, indicating dosage. They may have finished all the drops!
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. **Vision**: Check distance vision **SC** in the operated eye and best corrected for the non operated eye. **PH for the operated eye** if no improvement from the previous visit. Also be aware of type of IOL.
2. **Auto K/ Auto ref in the operated eye**
3. **Manual Keratometry Reading in the operated eye**: For difficult refractions and when unable to do Auto K.
4. **Refraction:** Manifest OU with add. Always include near vision. Be aware of multifocal IOLs.
5. **IOP for WHC, SW, JDP and BAM (If no complaints/ red eye)**
6. **Check pupils**

**End of Exam**

1. Route sheet should indicate PO visit.
2. Follow up should be in 2-3 months for a complete exam unless indicated differently.
3. For JDP follow up in 6 months.
4. Log out of EMR

# 1 DAY POST CORNEAL TRANSPLANT

1. **Chief Complaint:** Enter "Post-Op visit for surgery on xx/xx/xx – type of surgery (PKP, DSEK, Combined PKP and Cataract extraction) OD/OS" Any complaints? Pain, vision changes, questions?
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? The technician will provide a post op kit with written instructions. ***Pred forte q2h for one day*** and then QID, Antibiotic QID and NSAID QID, TID or BID. Review how to use the drops. In addition, Patients need to use the **shield at bedtime at least for** ***3 WEEKS*** to protect the eye while sleeping. ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. The technician will carefully remove the patch saving the protective shield and cleaning gently the area around the eye until the patient can easily open it.
2. **Vision**: Check distance vision **SC** in the operated eye and best corrected for the non operated eye.

**NOTE:**

- Visits on Day 2 – 14 is same as day one with exception that patient does not generally come in with a shield on, and steroid will likely being dosed at QID with antibiotic QID.
- **Additionally IOP is done by WHC on visits prior to day 7.**

**End of Exam**

1. Route sheet should indicate PO visit.
2. Follow up should be 2-4 days for Post op visit of the operated eye unless indicated differently.
3. Log out of EMR

# <u>4 WEEKS POST CORNEAL TRANSPLANT</u>

1. **Chief Complaint:** Any complaints? Pain, vision changes, questions?
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? ALWAYS update the eye medications in EMR, indicating dosage. ***They <u>SHOULD STILL BE USING THE STEROID</u>!***
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. **Vision**: Check distance vision **SC** in the operated eye and best corrected for the non operated eye. **PH for the operated eye** if no improvement from the previous visit.
2. **Auto K/ Auto ref in the operated eye**
3. **Manual Keratometry Reading in the operated eye**: For difficult refractions and when unable to do Auto K.
4. **<u>TOPOGRAPHY</u>**
5. **Refraction:** Manifest the operated eye with add. Always include near vision. Be aware of multifocal IOLs.
6. **IOP**
7. **Check pupils**

**End of Exam**

1. Route sheet should indicate PO visit.
2. Following post op visits, will include TOPO AND REF as requested.
3. Update medications as necessary
4. Log out of EMR

# 1 DAY POST PTERYGIUM SURGERY

1. **Chief Complaint:** Enter "Post-Op visit for surgery on xx/xx/xx – type of surgery (Pterygium with conj. Graft, etc…) OD/OS" Any complaints? Pain, questions?
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? The technician will instruct the Patient to use **Maxitrol ointment or Tobradex (Tobramycin/Dexamethasone) ointment QID in the operated eye**. ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. The technician will carefully remove the patch and gently clean the area around the eye until the patient can easily open it.
2. **Vision**: Check vision OU. Best corrected. PH if needed.
3. **IOP.**

**End of Exam**

1. Route sheet should indicate PO visit.
2. Patient must be aware that vision will be slightly blurry while they are using the maxitrol ointment.
3. Follow up should be 2-3 weeks for Post op visit of the operated eye unless indicated differently.
4. Log out of EMR

# POST OP YAG CAPSULOTOMY

**NOTE:** Done for secondary membrane so you expect an immediate vision improvement, unless there are corneal, retinal or nerve changes.

1. **Chief Complaint:** "Post-Op visit for YAG CAP on xx/xx/xx, OD/OS. Any complaints? Pain, vision changes.
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. **Vision**: (with glasses if wears) (need to note if cc, sc, CL or IOL) distance and near
2. **Auto K/ Auto ref in the operated eye**
3. **Refraction:** Manifest both eyes with add. Always include near vision. **PH for the operated eye** if no improvement from the previous visit.
4. **Check pupils**
5. **Slit lamp exam**, look at anterior chamber depth and for obvious abnormalities – if shallow chamber or any abnormalities with pupils or iris do not dilate.
6. **IOP for WHC, SW, JDP and BAM (assuming the eye is not red and Patient has no new complaints)** applanation is preferred method, if in doubt; you should ask the doctor before instilling flourescein. (**Don't do IOP for DJC)**
7. **Dilate for WHC and SW:** (Do not dilate if questionable refraction, pupils, motility or neurological symptoms, ASK). **Don't dilate for DJC, BAM or JDP**.

**End of Exam**

1. Route sheet should indicate PO visit.

2. Log out of EMR

# POST OP SLT and YAG PI

- **SLT** (Selective Laser Trabeculoplasty) done for **OAG** (Open Angle Glaucoma)
- **YAG PI** (Peripheral Iridotomy) done for **NAG** (Narrow Angle Glaucoma)

1. **Chief Complaint:** "Post-Op visit for SLT/LPI on xx/xx/xx, OD/OS". Any complaints? Pain, vision changes.
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. **Vision**: (with glasses if wears) (need to note if cc, sc, CL or IOL) distance and near. **PH as needed** if the vision has decreased.
2. **Check pupils**
3. **IOP for WHC, JDP, SW and BAM (assuming eye is not red and no new complaints):** applanation is preferred method, if in doubt; you should ask the doctor before instilling flourescein. (**Don't do IOP for DJC)**

**End of Exam**

1. Prescriptions recorded/updated in EMR, ERx'd or printed.
2. Route sheet should indicate PO visit.
3. Log out of EMR

# 1 DAY TRABECULECTOMY, AHMED VALVE, EXPRESS SHUNT

1. **Chief Complaint:** Enter "Post-Op visit for surgery on xx/xx/xx – type of surgery (Trabeculectomy, Ahmed Valve, Express shunt or combined with cataract extraction) OD/OS" Any complaints? Pain, vision changes, questions?
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? The technician will provide a post op kit with written instructions. ***Pred forte q2h***, Antibiotic QID and NSAID QID, TID or BID. Review how to use the drops. In addition, Patients need to use the shield at bedtime at least for ***3 WEEKS*** to protect the eye while sleeping. ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. The technician will carefully remove the patch saving the protective shield and cleaning gently the area around the eye until the patient can easily open it.
2. **Vision**: Check distance vision **SC** in the operated eye and best corrected for the non operated eye.
3. **IOP**

**End of Exam**

1. Route sheet should indicate PO visit.

2. Follow up should be 2-4 days for Post op visit of the operated eye unless indicated differently.

3. Log out of EMR

***NOTE:*** *For combined procedure 1-3 week post op visit would likely include a K&R. If in doubt, ASK!*

# 1 DAY VITRECTOMY

1. **Chief Complaint:** Enter “Post-Op visit for surgery on xx/xx/xx – type of surgery (Pars plana vitrectomy or combined with cataract extraction) OD/OS” Any complaints? Pain, vision changes, questions?
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient’s medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? The technician will provide a post op kit with written instructions. Steroid QID, Antibiotic QID, Atropine QID and NSAID QID, TID or BID. Review how to use the drops. In addition, Patients need to use the shield at bedtime at least for ***2 WEEKS*** to protect the eye while sleeping. ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

4. The technician will carefully remove the patch saving the protective shield and cleaning gently the area around the eye until the patient can easily open it.
5. **Vision**: Check distance vision **SC** in the operated eye and best corrected for the non operated eye.
6. **IOP**

**End of Exam**

4. Route sheet should indicate PO visit.

5. Follow up should be 2-4 days for Post op visit of the operated eye unless indicated differently.

6. Log out of EMR

***NOTE:*** *4 weeks post op visit would likely include a K&R. If in doubt, ASK!*

# CORNEAL CONSULT

1. **Chief Complaint:** Indicate referral Doctor and the reason why the patient was referred. Any complaints? Pain, vision changes.
2. **History of Present Illness**
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history.

**Exam**

1. **Vision**: (with glasses if wears) (need to note if cc, sc, CL or IOL) distance and near. **PH as needed** if the vision has decreased.
2. **Refraction:** Likely they were recently refracted. Do refraction as needed. (Ask patients if they were informed about refraction fee, up to $50) Always include near vision.
3. **Check pupils**
4. **DON'T DO IOP!, Do not put drops in eyes**
5. **Any testing needed will be directed by WHC.**

**End of Exam**

1. Prescriptions recorded/updated in EMR, ERx'd or printed.
2. Be sure check-off form is filled out, show doctor, if question (Diagnosis (medical and visual and Procedure(s)
3. Follow up appt indicated (any need to block slots? Specialty testing indicated?) Can patient be dilated, with what, immediately, need refraction, etc.
4. If patient is to return for specialty fit, print specialty fit form and have patient sign. Needs to be scanned into patient chart
5. Log out of EMR

# GLAUCOMA CONSULT

**ALWAYS CHECK:** date of last dilation/OCT, visual field, optic nerve photos.

**DO A VISUAL FIELD IF:**

- **There are no previous visual fields.**
- **Patient was referred due to visual field change.**
- **Last field was done over 1 year ago.**

1. **Chief Complaint:** Any complaints? Pain, vision changes.
2. **History of Present Illness:** When was the initial diagnosis, what treatment/drops have been used.
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of. Ask for any other problems since surgery.
4. **Current Medications:** Review Patient's medications **one by one**.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications: REVIEW** with patient the eye medications they are using, name and dosage. When was last drop used? ALWAYS update the eye medications in EMR, indicating dosage.
9. **Social History:** If not filled in before, Drugs?, ETOH?, Smoking?, ask if there is any change if filled in…
10. **Family history:** Review family history. Any glaucoma? Who? How severe?

**Exam**

1. **Vision**: (with glasses if wears) (need to note if cc, sc, CL or IOL) distance and near. **PH as needed** if the vision has decreased.
2. **Refraction: Only when the patient complains of blurred vision or wants new glasses.** (Ask patients if they were informed about refraction fee, up to $50) Always include near vision.
3. **Check pupils**
4. **Slit lamp exam**: look at anterior chamber depth and for obvious abnormalities – if shallow chamber or any abnormalities with pupils or iris do not dilate.
5. **IOP for SW:** applanation is preferred method, if in doubt; you should ask the doctor before instilling flourescein.
6. **Pachymetry:** If not done before.
7. **Dilate: <u>SW will dilated the patient.</u>**
8. **Anticipate the need for an OCT of Nerve if not done during the past year.**

**End of Exam**

1. Prescriptions recorded/updated in EMR, ERx'd or printed.

2. Be sure check-off form is filled out, show doctor, if question (Diagnosis (medical and visual and Procedure(s)

3. Follow up appt indicated (any need to block slots? Specialty testing indicated?) Can patient be dilated, with what, immediately, need refraction, etc.

4. Log out of EMR

# PRE-REFRACTIVE SURGERY SCREENING

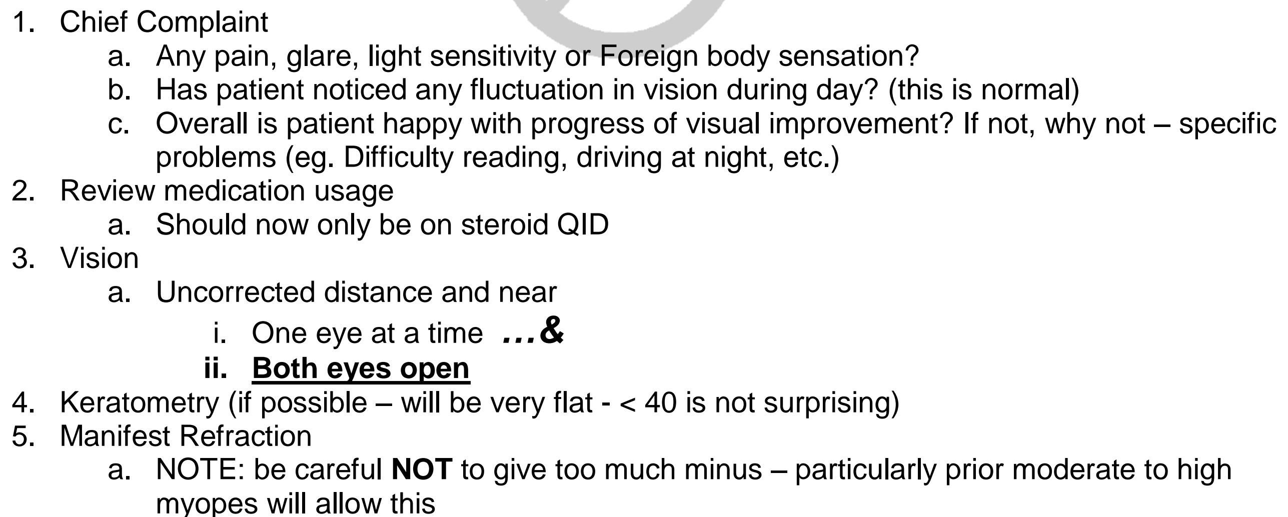
**Pre-Operative Workup**

1. **Chief Complaint:**
    - **a.** Why is patient interested in refractive surgery?
        - **i.** Contact lens problems, When was the last time they wore contacts and what type.
        - **ii.** Doesn't like glasses
        - **iii.** Job related – policeman, fireman, pilot, housewife with young children, etc.
2. **Past Medical History:**
    - **a.** Ocular history;
        - **i.** Infections, allergies, contacts (type, solutions wearing schedule), dry eye
        - **ii.** Glare and light sensitivity.
        - **iii.** Past ocular surgeries
    - **b.** Medical history
        - **i.** Diabetes, collagen vascular diseases (arthritis, sarcoid, lupus)
        - **ii.** Medications
3. **Correction of vision**
    - **a.** Wearing glasses – measure
    - **b.** Contacts – specs. (if possible)
4. **Measure vision**
    - **a.** Uncorrected distance/near
    - **b.** With current glasses – distance/near
    - **c.** With current contacts – distance/near
    - **d.** General Color Vision
    - **e.** Confrontational visual fields
5. **Refraction:**
    - a. Manifest – distance (with add if age appropriate)
6. **Pupil size:**
    - a. Room light
    - b. Dim room light
7. **Talk to patient during exam –** not to chat, but to get a feeling for how serious patient is about refractive surgery. Is this an initial – collect information type visit or has patient already done research and is looking to have procedure done?
    - a. If appropriate, give booklet on **LASIK**
8. **Check with WHC -**
    - a. Topography, Specular and Pachymetry, Pach Map
    - **b.** MD exam, then IOP and dilate
9. **Cyclopleged Refraction**

# 1 DAY POST REFRACTIVE SURGERY

Patient will have received post-op kit from surgery center with antibiotic and steroid (most likely Prednisolone Acetate and Ciloxan, but check, the pt will have been told to bring the medications with them). Patient will have been instructed to use drops q 2 hrs on the day of the procedure.

1. Chief Complaint
   a. Any pain, glare or light sensitivity since the procedure.
   b. Has patient noted that the uncorrected vision is better than pre-op?
2. Review the medications that patient was using (see above)
3. Was patient wearing protective goggles when brought in? Did they sleep in the goggles as instructed?
4. Vision
   a. Uncorrected distance and near
      i. One eye at a time
      ii. Both eyes open
5. Review post op meds:
   a. Antibiotic – QID for three days then D/C
   b. Steroid – QID until instructed otherwise.



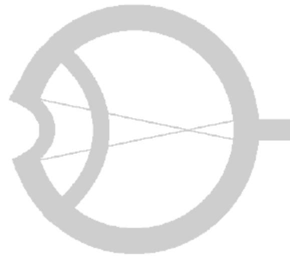
# 1 WEEK POST REFRACTIVE SURGERY

1. Chief Complaint
   a. Any pain, glare, light sensitivity or Foreign body sensation?
   b. Has patient noticed any fluctuation in vision during day? (this is normal)
   c. Overall is patient happy with progress of visual improvement? If not, why not – specific problems (eg. Difficulty reading, driving at night, etc.)
2. Review medication usage
   a. Should now only be on steroid QID
3. Vision
   a. Uncorrected distance and near
      i. One eye at a time ***…&***
      **ii. <u>Both eyes open</u>**
4. Keratometry (if possible – will be very flat - < 40 is not surprising)
5. Manifest Refraction
   a. NOTE: be careful **NOT** to give too much minus – particularly prior moderate to high myopes will allow this

# POST OP WEEK #4, 12 0R 26 REFRACTIVE SURGERY

**(Month 1, 3 or 6)**

1. Chief Complaint
    a. Any pain, glare, light sensitivity or Foreign body sensation?
    b. Overall is patient happy with progress of visual improvement? If not, why not – specific problems (eg. Difficulty reading, driving at night, etc.)
2. Review medication usage – if appropriate
3. Vision
    a. Uncorrected distance and near
        i. One eye at a time
        ii. Both eyes open
4. Keratometry (if possible – will be very flat - < 40 is not surprising)
5. Topography
6. Specular Microscopy
7. Manifest Refraction
    a. NOTE: be careful **NOT** to give too much minus – particularly those patient who used to be moderate to high myopes will allow this
8. Check with WHC to see about Cyclopleged refraction or any other testing



# CONTACT LENS FIT

- *Contact lens fit should be done only if there are no complaints/evidence of redness, infections, allergies, uveitis, corneal abnormalities, etc… If in doubt ASK the Doctor before you start!*
- *Be sure to REVIEW the charges with the Patient before you start: Regular fit. *** $**100 for I&R** (If they haven't worn contacts before) or $**50 for only a fit** (If they are familiar with insertion, removal and general care of contacts.)***.*
- ***Contact lens specialty fit require a TOPOGRAPHY and written consent**, Charge is $350 for both eyes plus the contacts (From $75 to 300 per eye) Form should be signed and in chart*
- *If the last complete eye exam was done over 6 months ago, they should have a complete exam also.*

1. **Chief Complaint**
2. **History of Present Illness:** Are they wearing contacts from somewhere else? What type? Any problems? Contact lens wearing time? Do they sleep in lenses? If presbyopic, having trouble with near vision? Establish if you need to introduce options for improving near vision, such as OTC reading glasses, monovision or multifocal contacts.
3. **Past History:** Review any changes in medical conditions looking for **any new diagnoses** we should be aware of). Head, Heart, Lungs, GI, GU, Nervous system, Extremities. If diabetic: Last BS? Hemoglobin A1C?
4. **Current Medications:** Review Patient's medications **one by one**. Inactivate medications approximately when stopped.
5. **Review of Systems:** See #3 above.
6. **Allergies:** Review any change in allergies.
7. **Past Ocular History:** Ask if patient has been to another eye care practitioner since being at HEPS. Enter any procedure, laser, etc. not previously recorded.
8. **Ocular Medications:** REVIEW with patient the eye medications they are using, name and dosage. When was last drop used?
9. **Review Social and family history.**

**Exam**

1. **Vision** (with current glasses/Contacts if wears) (need to note if cc, sc, CL or IOL) distance and near
2. **Auto Ref/Auto K:** If not recently done. **Keratometry**: If no K readings in chart.
3. **Refraction with add when needed**: For all VSP patients, when there are vision changes or when last refraction was done over 6 months ago.
4. **Check pupils** (If abnormal, do not dilate)
5. **Select the appropriate contact lens with the Doctor according to refraction and keratometry.**
6. **Calculate the sphere power using the vertex calculator.**
7. **Insert the contact lens in the appropriate eye** (Patient should do it in front of the technician when they have worn that type of contacts before as they may need to review the technique).
8. **Slit lamp exam evaluation**, look at the slight contact lens movement as patient blinks and looks up. For toric contacts, look for the marker at 6. If in doubt ask!
9. **Do a spherical over refraction for distance in each eye –unless monovision-**(You are not expecting a big change; it shouldn't be more than +/-0.25 to 0.75D).
10. **Record the results in the contact lens template.**
11. **Always show both eyes open.**
12. **Proceed with I&R** when needed.