



SHORT RECORD ASSESSMENT

PATIENT	DONE/NOT APPLICABLE	OMISSION
1. Is/are the reason(s) for presenting (chief complaints) identified?	D1	No
2. Is the health history including the use of medications explored?	D1	No
3. Is the relevant family ocular health history recorded?	D1	No
4. Were the external eye and adnexa examined?	D1	No
5. Were the tissues of the anterior segment examined?	D1	No
6. Were the tissues of the posterior segment examined (through a dilated pupil when indicated)?	D1	No
7. Were the pupillary reflexes tested?	D1	No
8. Were intra-ocular pressures measured when indicated?	D1	No
9. Is the presenting monocular visual acuity at distance recorded?	D1	No
10. Is the presenting monocular visual acuity at near recorded?	D1	No
11. Was a measure of refraction conducted?	D1	No
12. Were the resulting monocular acuities recorded for any prescription change?	D1	No
13. Was the magnitude and direction of any distance horizontal deviation measured?	D1	No
14. Was the magnitude and direction of any near horizontal deviation measured?	D1	No
15. Does the record show that the member diagnosed or addressed all problems evident in the case history and basic examination?	D1	No

Please provide the Committee with specific comments that you believe are critical to this file that has not been captured by the above questions.