COLLEGE OF Optometrists OF ONTARIO

COMPLETE RECORD ASSESSMENT

	Done D	Omission O	Serious Omission S	Not Applicable	Illegible I
Year of Birth					
Gender					
1. Case History (OPR 4.2, 5.1)					
1.1 Is there enough information on the file to identify and contact the patient? e.g., name, address, telephone number(s).					
1.2 Is the patient file clear as to the dates of every patient visit?					
1.3 Is it possible to tell the eye(s) and date that any documents appended to the record relate to?					
1.4 Is/are the reason(s) for presenting (chief complaints) identified?					
1.5 Is/are the reason(s) for presenting and/or other symptom(s) explored?					
1.6 Is the previous eye care history explored?					
1.7 Is the use of visual appliances explored? *(If contact lenses are used, please complete Section 7C)*					
1.8 Is the personal history of ocular disease/trauma explored?					
1.9 Is the health history including the use of medications and allergies to medications explored?					
1.10 Is the relevant family ocular health history recorded?					
1.11 Are the visual demands evident?					
2. Ocular Health Assessment (OPR 4.2, 6.1, 6.8, 7.2) *Were the following examined when indicated by the OPR:*					
2.1 The external eye and adnexa?					
2.2 The tissues of the anterior segment?					
2.3 The tissues of the posterior segment?					
2.4 The macular area?					
2.5 The tissues of the eye through a dilated pupil?					
2.6 The pupillary reflexes tested?					
Is the following information quantified appropriately for the specific patient when indicated by the OPR:					
2.7 Disc topography?					
2.8 Retinal vasculature?					
2.9 Depth of the anterior chamber					
2.10 The intra-ocular pressure?					
2.11 Central Corneal Thickness?					
2.12 Visual field results including test parameters?					
2.13 Does the record identify pharmacological agent(s) used, i.e., drug, concentration, and dosage?					

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2.14 Is it possible to tell the appearance of any physical anomalies to such a degree that future changes could be detected? (Are there appropriate indications of scale and position in the eye or adnexa?)					
3. Refractive and Accommodative Assessment (OPR 4.2, 6.3, 7.6) *(when indicated by the OPR)*					
3.1 Is the presenting monocular visual acuity at distance recorded?					
3.2 Is the presenting monocular visual acuity at near recorded, if indicated?					
3.3 Was refractive status determined?					
3.4 Were the monocular best-corrected visual acuities at distance recorded?					
3.5 Were corneal curvatures measured?					
3.6 Was the accommodative system investigated, if indicated?					
3.7 Was a cycloplegic exam performed?					
3.8 Is it possible to tell from the record the focal power for any spectacle lenses is use?					
4. Oculo-Motor/Sensory Assessment (4.2, 6.7) *Is it possible to tell the following from the record when indicated by the OPR:*					
4.1 Whether the patient was strabismic or non-strabismic?					
4.2 The magnitude **and** direction of any distance horizontal phoria of a non-strabismic patient as measured by one or more methods, e.g., alternating cover test, vonGraefe, or Maddox rod? **OR** the magnitude, direction, frequency **and** laterality at distance of a strabismus?					
4.3 The magnitude **and** direction of any near horizontal phoria of a nonstrabismic patient as measured by one or more methods, e.g., alternating cover test with prisms, vonGraefe, Maddox rod? **OR** the magnitude, direction, frequency **and** laterality at near of a strabismus.					
4.4 The motor fusion limits (prism to blur or break) at distance?					
4.5 The motor fusion limits (prism to blur or break) at near					
4.6 The vertical phoria?					
4.7 The colour vision status?					
4.8 The contrast sensitivity?					
4.9 The stereoacuity?					
4.10 The sensory fusion status?					
5. Professional Judgment/Case Management (OPR 5.1) *As an aid to your analysis of this aspect of care, study the case history and findings and list all significant problems that you can identify. Consider the information available from previous examinations, where necessary.*					
5.1 Does the record show that the member investigated and diagnosed all problems evident in the case history?					

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5.2 Does the record show that the member assessed and diagnosed all problems evident in the basic examination?					
5.3 Does the record show an appropriate management plan/patient counselling? (This may include patient education, further diagnostic assessment, optometric treatment, or referral.)					
5.4 In cases where a refractive correction was prescribed, can you find adequate support for the distance prescription?					
5.5 In cases where a refractive correction was prescribed, can you find adequate support for the near prescription?					
5.6 If a consultation/referral has been noted as necessary, has the member arranged the appointment and ensured that the reason(s) for referral/consultation and the relevant clinical information are conveyed to the second practitioner?					
TREATMENT SERVICES					
6. Spectacle Treatment (OPR 6.4, 6.6, 6.7) *Is it possible to tell from the patient record:*					
6.1 What information was provided to the laboratory, if the member provided spectacle therapy? Was appropriate or relevant specification provided to the laboratory if member provided spectacle therapy?					
6.2 If a prescription for spectacles was issued?					
6.3 Indications for use of appliance, e.g., constant, distance only, near only?					
6.4 In cases where the member provided spectacle treatment, does the record show the results of verification of all relevant specifications noted above?					
7A. Contact Lens Diagnosis (New Fits) (OPR 6.5)					
7A.1 Was information gathered for the purpose of contact lens consultation, i.e., previous wear, allergy, vocational and avocational requirements, medications, and any other related factors that might affect contact lens performance?					
7A.2 Was information gathered on the physical characteristics of the eye and adnexa, i.e., cornea, conjunctiva, tear film, etc.?					
7B. Contact Lens Treatment (OPR 6.5) *(Delivery of new contact lenses)*					
7B.1 Is it possible to tell from the patient file exactly what lenses had been ordered for the patient?					
If so, were the following parameters specified for the lenses: (OPR 6.5) (*Where certain parameters are "standard" and available from the manufacturer, their recording could be considered "not applicable")*					
7B.2 Does the record show that the patient was counselled regarding contact lens wear?					

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7B.3 Are the care products recommended for use evident from the record?					
7C. Ongoing Care for Contact Lenses (OPR 6.5) *In progress evaluations for a new case or in monitoring of an established case, was it evident that case history, monitoring and, where necessary, modification was adequate to determine that there was:*					
7C.1 satisfactory wearing time?					
7C.2 acceptable comfort with lenses in place?					
7C.3 compliance with recommendations on lens handling, care and wearing time?					
7C.4 adequate refractive correction?					
7C.5 satisfactory spectacle acuity?					
7C.6 no significant change to the ocular surfaces from the baseline?					
7C.7 satisfactory contact lens condition and fitting characteristics?					
7D. Contact Lens Problem Solving (OPR 6.5) *In cases in which there were problems with contact lens wear, does the record show:*					
7D.1 identification and adequate exploration of the problem(s) presented by the patient?					
7D.2 collection of adequate and appropriate clinical information?					
7D.3 analysis of the symptoms and findings to determine the status of the problem being followed?					
7D.4 an outline of the treatment plan?					
8. Vision Treatment (OPR 6.7) *(Vision training or orthoptics subsequent to binocular vision work-up and prescription of a treatment plan)*					
8.1 Is it possible to tell from the record the treatment procedures carried out at each session?					
8.2 Were periodic assessments of the function(s) undergoing treatment carried out?					
8.3 Does the record show that testing to enable decisions about intensification, alteration or termination of treatment was done?					
9. Low Vision Treatment (OPR 6.8) *(Subsequent to initial diagnostic evaluation and prescription of a treatment plan)*					
9.1 Is it possible to determine from the record the exact appliance(s) provided to the patient?					
9.2 Are the appliances generally accepted as effective for the identified needs?					
9.3 Does the record show that training in the use of any appliances was given?					
9.4 Was follow-up arranged to determine the efficacy of treatment?					