

SHORT RECORD ASSESSMENT

PATIENT	DONE/NOT APPLICABLE	OMISSION
1. Is/are the reason(s) for presenting (chief complaints) identified? (OPR 4.2, 5.1)		
2. Is the health history including the use of medications explored? (OPR 4.2, 5.1)		
3. Is the relevant family ocular health history recorded? (OPR 4.2, 5.1)		
4. Were the tissues of the anterior segment examined? (OPR 6.1)		
5. Were the tissues of the posterior segment examined (through a dilated pupil when indicated)? (OPR 6.2)		
6. Were the pupillary reflexes tested? (OPR 4.2)		
7. Were all risk factors indicating glaucoma explored (if applicable)? (OPR 4.2, 6.8, 7.2)		
8. Is the presenting monocular visual acuity at near and distance recorded? (OPR 4.2)		
9. Was an appropriate measure of refraction conducted? (OPR 4.2, 6.3, 7.6)		
10. Were the resulting monocular acuities recorded for any prescription change? (OPR 4.2)		
11. Were all appropriate measures of binocularity carried out at distance and near? (OPR 4.2, 6.7)		
12. Does the record show that the member diagnosed or addressed all problems evident in the case history and basic examination, when indicated? (OPR 5.1)		
<p>Please provide the Committee with specific comments that you believe are critical to this file that has not been captured by the above questions.</p>		