ADVICE & GUIDELINES ON PROFESSIONAL CONDUCT

FOR DISPENSING OPTICIANS

APPENDIX B [1] - CONTACT LENS RECORDS

The following details the areas which should be addressed when making records of patients' appointments -

A. FOR INITIAL APPOINTMENT OF A NEW PATIENT:

(1) **General Information**

Date fitting commenced
Name
Address
Telephone numbers
Date of birth
Referring optometrist/OMP
Spectacle prescription and VAs
Any initial contraindications to CL fitting
Patient's reason for wanting contact lenses
Occupation and working environment
Sports, hobbies and pastimes
Allergies/Hay Fever (Seasonal allergic conjunctivitis)
Personal and family ocular history
Personal and family general health and specific pathologies
Medications
Smoker
Driving
General practitioner
Contact lens history

(2) **Detailed examination of the anterior eye**

Should include space for assessments of:
Each layer of the cornea
Limbus
Conjunctiva
Lids, lid margins, and lid position (upper and lower)
Lid tensions
Tear assessments – quality and quantity
Other relevant data (e.g. horizontal visible iris diameter, pupil diameter [varied illumination], vertical palpebral aperture)
A grading scale and diagrammatic recording should be used.

(3) **Keratometric information**

Type of instrument, values measured and mire quality; dioptric values, radii and axes/meridians. Topographical information if available.

(4) **Lens options discussed with the patient**

Should be recorded.

(5) **Contraindications found in the examination**

(6) **Trial lenses used**

With full details of fit assessment, over refraction and visual acuities.

(7) **Details of lenses to be ordered**

(8) **Next scheduled appointment.**

B. FOR COLLECTION APPOINTMENT:

(1) **Instruction given to the patient**

Lens handling and ability to insert, removal, recentration; case hygiene, personal hygiene, care system and wearing schedule.

An assessment of the patient's ability to handle their lenses should be recorded.

(2) **The recommended care system**

(3) **Assessment of lens fit and visual acuities**

(4) **Recommended next aftercare appointment and attendance record**

(5) **Patient acknowledgement form (**DoHCL1 – now discontinued***)***

Should be completed and attached to the record.

C. FOR SUBSEQUENT APPOINTMENTS:

(1) **General information**

History and symptoms since last visit
Wearing pattern
Patient's impressions of vision and comfort
Care system, compliance and handling

(2) **Over refraction**

Visual acuities with lenses
Objective assessment *where appropriate* (retinoscopy/autorefractor)
Subjective assessment and acuities
Confirmation tests (duochrome, + 1.00 blur, pinhole) where appropriate

(3) **Examination of lenses on the eyes**

Assessment of lens condition

(4) **Other examinations the practitioner considers appropriate**

e.g. Pre-lens tear break-up time, keratometry.

(5) **Detailed examination of the anterior eye**

Should include space for assessments of :
Each layer of the cornea
Limbus
Conjunctiva
Lids and lid margins
Tears
Where possible a grading scale and diagrammatic recording should be used.

(6) **Conclusions/Advice/Actions**

Space should be available for practitioners to record, for instance, changes in wearing pattern, refit, replacement, discontinue lens wear (temporary or permanent), change in care system, adjustments to power or fit, etc. This should include the rational for changes including patient requests to meet any specific challenges, circumstances and requirements. Also included under this heading would be advice on time of next contact lens aftercare check and/or full eye examination.

(7) **Contact Lens Specification**

The issue of the contact lens specification and its expiry date should be noted – and it is advisable that a copy be made of the document issued and kept in the patient's records.

See Appendix B [2] Contact Lens Specification for further information.