ADVICE & GUIDELINES ON PROFESSIONAL CONDUCT

FOR DISPENSING OPTICIANS

APPENDIX B - CONTACT LENS RECORDS

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 VA's
Patient's reason for wanting contact lenses
Occupation and working environment
Sports, hobbies and pastimes
Allergies
Personal ocular history – Contact lens history
General health and specific pathology
Medications
Driving
General practitioner

(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
Other relevant data (e.g. horizontal visible iris diameter, pupil diameter, palpebral aperture, diameters)

A grading scale and diagrammatic recording should be used.

(3) **Keratometry**

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

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

Should be recorded.

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

(6) **Trial lenses used**

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

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

(8) Date of next appointment if appropriate.

B. FOR COLLECTION APPOINTMENT:

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

Lens handling and ability to insert, removal, 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) or similar**

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

(2) **Over refraction**

Visual acuities with lenses
Objective assessment *where appropriate* (retinoscopy/autorefractor)
Subjective assessment and acuities

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

Details of lens fit and behaviour
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) **Patients lens handling/Hygiene/Compliance**

Space should be available for practitioner's comments.

(7) **Conclusions/Advice/Actions**

Space should be available for opticians 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. Also included under this heading would be advice on time of next contact lens aftercare check and/or full eye examination.

In paragraphs 18 to 25, dispensing opticians are advised as to the keeping and storing of patients' records and the effect of the Access to Health Records Act 1990; and in paragraph 19 they are enjoined to preserve the records' confidentiality. In relation to contact lens work this advice is particularly important.

Where aftercare is concerned, when a patient is told of the arrangements for aftercare, or afterwards, if it appears that the patient will not return for further consultation or treatment despite several reminders; or, if faced with a downright refusal, the contact lens optician should record the facts in his records. No further lenses should be supplied without the patient attending for aftercare.