

# 2018 SEATTLE/KING COUNTY CLINIC PATIENT VISION RECORD

<b>PATIENT INTAKE</b>	Station: _____	Intake Provider: _____	HT: _____	WT: _____
BP (<180/100 - Dental): _____	Pulse: _____	Temp: _____	Gluc/if Diabetic (<200 Dental Extract): _____	
POS (+) SCREEN TB: <input type="checkbox"/> N <input type="checkbox"/> Y Measles: <input type="checkbox"/> N <input type="checkbox"/> Y Scabies: <input type="checkbox"/> N <input type="checkbox"/> Y Other: _____ <input type="checkbox"/> N <input type="checkbox"/> Y				

PATIENT LABEL  
REQUIRED  
PLACE PATIENT  
LABEL IN THIS BOX

<b>HEALTH HISTORY</b>	<b>Nervous System</b>	<b>Infectious Disease</b>
<input type="checkbox"/> NONE	<input type="checkbox"/> Seizures	<input type="checkbox"/> Active infectious disease
<input type="checkbox"/> Recent hospitalization	<input type="checkbox"/> Stroke	Type: _____
<b>Cardio / Circulatory</b>	<b>Reproductive</b>	SX: <input type="checkbox"/> Respiratory illness
<input type="checkbox"/> Angina	<input type="checkbox"/> Breastfeeding (currently)	<input type="checkbox"/> Gastro illness
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Fever last 24 hours
<input type="checkbox"/> Bleeding disorder	<b>Respiratory</b>	<input type="checkbox"/> Hepatitis A B C
<input type="checkbox"/> Heart attack Yr: _____	<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV
<input type="checkbox"/> Heart disease	<b>Other</b>	<input type="checkbox"/> MRSA
<input type="checkbox"/> Hyper / Hypotension	<input type="checkbox"/> Radiation therapy: Head / Neck	<input type="checkbox"/> STI: _____
<b>Dental</b>	<b>Psychosocial</b>	<b>Vaccinations</b>
<input type="checkbox"/> Adverse dental RXN	<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Hep A / Hep B
<input type="checkbox"/> Bisphosphonate / ever used	<input type="checkbox"/> Anxiety	<b>Vision</b>
<input type="checkbox"/> Dental anxiety	<input type="checkbox"/> Behavioral disorders/concerns	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Oral cancer	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Conjunctivitis: current / recurrent
<b>Digestive / Excretory</b>	<input type="checkbox"/> E-Cigarette/Vapor use	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Asplenia	<input type="checkbox"/> Marijuana use	<input type="checkbox"/> Vision loss
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Tobacco use	<b>Recommendations:</b>
<b>Endocrine</b>	<input type="checkbox"/> Intravenous drug use	<input type="checkbox"/> FOCUS (Behavioral Health App)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Opioid use	<input type="checkbox"/> Opioid Risk Assessment
<b>Muscular / Skeletal</b>	<input type="checkbox"/> Other substance/drug use	<input type="checkbox"/> NTHK Issued
<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Overdosed on drugs	

<b>ALLERGIES</b>	<b>CURRENT RX</b>	
<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Blood thinners
<input type="checkbox"/> Codeine/Narcotics	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Hormones
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Bisphosphonate	<input type="checkbox"/> Hydroxychloroquine
<input type="checkbox"/> Other: _____	<input type="checkbox"/> None	<input type="checkbox"/> Insulin
<input type="checkbox"/> Latex	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Metformin
<input type="checkbox"/> Penicillin/Antibiotics	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Methotrexate
<input type="checkbox"/> Sulfa		<input type="checkbox"/> Statins
		<input type="checkbox"/> Steroids
		<input type="checkbox"/> Tamoxifen

	COMPLETED VISION SERVICES	QTY	PROVIDER/TECH NAME (Please Print)
<input type="checkbox"/>	Vision Triage	1	
<input type="checkbox"/>	Visual Acuity	1	
<input type="checkbox"/>	Refraction	1	
<input type="checkbox"/>	Pressure	1	
<input type="checkbox"/>	Dilation	1	
<input type="checkbox"/>	Slit Lamp	1	
<input type="checkbox"/>	OCT	1	
<input type="checkbox"/>	Readers Dispensed		
<input type="checkbox"/>	Single Vision Ordered		
<input type="checkbox"/>	Bifocals Ordered		

**DX:**  Cataracts  Diabetic Ret.  Glaucoma  Maculopathy

Pharmacists to transcribe RX Written, Quantity & Dosage

**Pharmacist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Prescriptions written to be filled off site were reviewed and confirmed by Seattle/King County Clinic Pharmacist.

**DIRECTOR AUTHORIZATION**

<input type="checkbox"/> RFC: _____	<b>EMG REF DX:</b> <input type="checkbox"/> Cataracts <input type="checkbox"/> Diabetic Ret. <input type="checkbox"/> Maculopathy
<input type="checkbox"/> EMG REF: _____	<input type="checkbox"/> Maculopathy <input type="checkbox"/> Other: _____

<b>VISION TRIAGE</b> Date of last eye exam: _____	Wear Glasses: <input type="checkbox"/> Yes <input type="checkbox"/> No	Wear Contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Chief Complaint: \_\_\_\_\_

Vision changes in last yr? <input type="checkbox"/> None <input type="checkbox"/> Yes ( <input type="checkbox"/> Distance <input type="checkbox"/> Up-Close)	Current Eye RX: <input type="checkbox"/> Eye Drops <input type="checkbox"/> Glaucoma Drops <input type="checkbox"/> Other:
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Complaints: <input type="checkbox"/> Pain <input type="checkbox"/> Irritation <input type="checkbox"/> Flashes <input type="checkbox"/> Floaters	Family Hx: <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Retinal Detachment
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**Does the patient have a valid SPRX with them that was written with the past 12 months?**

<input type="checkbox"/> No, patient routed to Vision <b>Step 2 Visual Acuity</b>	<input type="checkbox"/> Yes, patient routed to Vision <b>Step 8 Optical/Dispensing</b>
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**VISUAL ACUITY**  SC  SPRX  SCL  RGP

DVA OD 20 / \_\_\_\_\_ OS 20 / \_\_\_\_\_

**PRESSURE**  TP  TA  REFUSED  SOFT PALPATION  OTHER: \_\_\_\_\_

OD \_\_\_\_\_ OS \_\_\_\_\_ Time: \_\_\_\_\_ AM PM Tech Initials: \_\_\_\_\_

**PUPILS**  PERRLA  - + APD SIZE \_\_\_\_\_

**ANGLES**  Open on PLE  Suspect Occludable on PLE (forward to SLE)

**MOTILITY & COVER**

EOMs F&S  Other: \_\_\_\_\_

**GONIO**

I	S	N	T
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Cover - Ortho  Other: \_\_\_\_\_

Open on SLE Grade: \_\_\_\_\_  Suspect Occludable on SLE (ANA)

**CURRENT SPRX**  N/A  READERS +

**DILATION**  CONTRAINDICATED  REFUSED

OD									
		X			ADD				
OS		X			ADD				

PD M.5% M1 N1 N2.5% TIME: \_\_\_\_\_ READY: \_\_\_\_\_

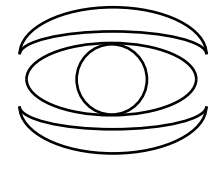
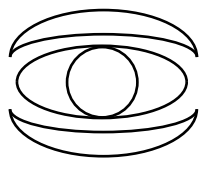
SV  BF  Tri  PAL

**AUTOREFRACTOR**

**SLIT LAMP ANTERIOR**  ALL STRUCTURES WNL

OD									
			X						
K			X						
OS			X						
K			X						

FINDINGS (Please Print Clearly): \_\_\_\_\_

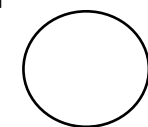



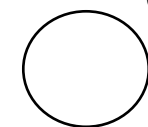
**REFRACTION**

**SLIT LAMP POSTERIOR**  ALL STRUCTURES WNL

OD									
		X			ADD		20/		
OS		X			ADD		20/		

FINDINGS (Please Print Clearly): \_\_\_\_\_

ONH  


ONH  


PRISM: OD \_\_\_\_\_ B I/O OS \_\_\_\_\_ B I/O  N

**OPTICAL**  NO CORRECTION NEEDED

ONH  


ONH  


No SPRX given due to:  
 Cataract  Retina  Other \_\_\_\_\_

OCT

PROCEED TO OPTICAL

SV  BF  READERS ONLY +  
 Current RX (within 12 months) Confirmed

C/D: OD \_\_\_\_\_ X \_\_\_\_\_ OS \_\_\_\_\_ X \_\_\_\_\_

**ASSESSMENT**

**OCT INTERPRETATION**  ONH  MAC  RETINA  Other \_\_\_\_\_

RX WRITTEN: Complete section on page 1.

**PROVIDERS:** See page 1 of the Patient Vision Record.  
 Check the box to indicate the service is complete, indicate any diagnosis and print your name.

# 2018 SEATTLE/KING COUNTY CLINIC PRESCRIPTION EYEGLASS ORDER FORM

Patient Name (as printed on label): \_\_\_\_\_ Patient ID# (as printed on label) P \_\_\_\_\_

**PATIENT ACKNOWLEDGMENT OF EYEGLASS ORDER:**

My prescription eyeglass order has been fully explained to me, and I have complete understanding of what I will be receiving.

The prescription for my new eyeglasses was:      Written at SKC Clinic                              Provided by me from another clinic

I understand that I am receiving:                      Single vision lenses                              Bifocal lenses

**Patient Signature:** \_\_\_\_\_

**Patient's mailing address MUST be confirmed at Vision Exit:**

Deliver c/o (Name): \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**READERS**   (+1.0)   (+1.5)   (+2.0)   (+2.5)   (+3.0)   (+3.5)

**DISPENSING PROVIDER NAME (PRINTED):**

**PROVIDERS:** See page 1 of the Patient Vision Record, check the appropriate box(es), track quantity of items and print name.

<b>PLACE PATIENT LABEL AT FRAME CHECK OUT</b>	LENS DESIGN: <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal (FT-28)	
	LENS MATERIAL: <input type="checkbox"/> Polycarbonate	JPOS:

EYE	SPHERE	CYLINDER	AXIS	ADD	SEG. HEIGHT
RIGHT (OD):					
LEFT (OS):					
DISTANCE PD	RE/OD	LE/OS	NEAR PD	RE/OD	LE/OS
	<input type="checkbox"/> Only 1 PD Measurement			<input type="checkbox"/> Only 1 PD Measurement	
FRAME INFORMATION	<input type="checkbox"/> Metal <input type="checkbox"/> Plastic		Brand/Style Name:		
	Color: _____		_____ <input type="checkbox"/> _____	_____	_____
			Eye Size	Bridge Size	Temple

<b>PLACE PATIENT LABEL AT FRAME CHECK OUT</b>	LENS DESIGN: <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal (FT-28)	
	LENS MATERIAL: <input type="checkbox"/> Polycarbonate	JPOS:

EYE	SPHERE	CYLINDER	AXIS	ADD	SEG. HEIGHT
RIGHT (OD):					
LEFT (OS):					
DISTANCE PD	RE/OD	LE/OS	NEAR PD	RE/OD	LE/OS
	<input type="checkbox"/> Only 1 PD Measurement			<input type="checkbox"/> Only 1 PD Measurement	
FRAME INFORMATION	<input type="checkbox"/> Metal <input type="checkbox"/> Plastic		Brand/Style Name:		
	Color: _____		_____ <input type="checkbox"/> _____	_____	_____
			Eye Size	Bridge Size	Temple