2018 SEATTLE/KING COUNTY CLINIC
PATIENT VISION RECORD

PATIENT LABEL REQUIRED
PLACE PATIENT LABEL IN THIS BOX

PATIENT INTAKE Station: Intake Provider: HT: WT:

BP (<180/100 - Dental): Pulse: Temp: Gluc/if Diabetic (<200 Dental Extract):

POS (+) SCREEN TB: ☐ N ☐ Y Measles: ☐ N ☐ Y Scabies: ☐ N ☐ Y Other: ☐ N ☐ Y

HEALTH HISTORY

☐ **NONE**
☐ **Recent hospitalization**

Cardio / Circulatory
☐ Angina
☐ Arrhythmia
☐ Bleeding disorder
☐ Heart attack Yr:____
☐ Heart disease
☐ Hyper / Hypotension

Dental
☐ Adverse dental RXN
☐ Bisphosphonate / ever used
☐ Dental anxiety
☐ Oral cancer

Digestive / Excretory
☐ Asplenia
☐ Liver disease

Endocrine
☐ Diabetes

Muscular / Skeletal
☐ Joint replacement

Nervous System
☐ Seizures
☐ Stroke

Reproductive
☐ Breastfeeding (currently)
☐ Pregnant

Respiratory
☐ Asthma

Other
☐ Radiation therapy: Head / Neck

Psychosocial
☐ Alcohol use
☐ Anxiety
☐ Behavioral disorders/concerns
☐ Emotional concerns
☐ E-Cigarette/Vapor use
☐ Marijuana use
☐ Tobacco use
☐ Intravenous drug use
☐ Opioid use
☐ Other substance/drug use
☐ Overdosed on drugs

Infectious Disease
☐ Active infectious disease
Type: ____________
SX: ☐ Respiratory illness
☐ Gastro illness
☐ Fever last 24 hours
☐ Hepatitis A B C
☐ HIV
☐ MRSA
☐ STI: ____________

Vaccinations
☐ Hep A / Hep B

Vision
☐ Cataracts
☐ Conjunctivitis: current / recurrent
☐ Glaucoma
☐ Vision loss

Recommendations:
☐ FOCUS (Behavioral Health App)
☐ Opioid Risk Assessment
☐ NTHK Issued

ALLERGIES
☐ None
☐ Aspirin
☐ Other:
☐ Clindamycin
☐ Codeine/Narcotics
☐ Erythromycin
☐ Latex
☐ Penicillin/Antibiotics
☐ Sulfa

CURRENT RX
☐ None
☐ Antibiotics
☐ Other:
☐ Antidepressants
☐ Antihistamine
☐ Bisphosphonate
☐ Blood thinners
☐ Hormones
☐ Hydroxychloroquine
☐ Insulin
☐ Metformin
☐ Methotrexate
☐ Statins
☐ Steroids
☐ Tamoxifen

	COMPLETED VISION SERVICES	QTY	PROVIDER/TECH NAME (Please Print)
☐	Vision Triage	1	
☐	Visual Acuity	1	
☐	Refraction	1	
☐	Pressure	1	
☐	Dilation	1	
☐	Slit Lamp	1	
☐	OCT	1	
☐	Readers Dispensed		
☐	Single Vision Ordered		
☐	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

☐ RFC: ______________________________
☐ EMG REF:

EMG REF DX: ☐ Cataracts ☐ Diabetic Ret. ☐ Maculopathy ☐ Maculopathy ☐ Other:

SAMPLE

VISION TRIAGE Date of last eye exam:	Wear Glasses: ☐ Yes ☐ No Wear Contacts: ☐ Yes ☐ No

Chief Complaint:

Vision changes in last yr? ☐ None ☐ Yes (☐ Distance ☐ Up-Close)	Current Eye RX: ☐ Eye Drops ☐ Glaucoma Drops ☐ Other:
Complaints: ☐ Pain ☐ Irritation ☐ Flashes ☐ Floaters	Family Hx: ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment

Does the patient have a valid SPRX with them that was written with the past 12 months?

☐ No, patient routed to Vision **Step 2 Visual Acuity**	☐ Yes, patient routed to Vision **Step 8 Optical/Dispensing**

VISUAL ACUITY ☐ SC ☐ SPRX ☐ SCL ☐ RGP

DVA OD 20 / OS 20 /

PUPILS ☐ PERRLA ☐ - + APD SIZE

MOTILITY & COVER

☐ EOMs F&S ☐ Other:

☐ Cover - Ortho ☐ Other:

CURRENT SPRX ☐ N/A ☐ READERS +

OD			X		ADD	
OS			X		ADD	

☐ SV ☐ BF ☐ Tri ☐ PAL

AUTOREFRACTOR

OD			x	
K			x	
OS			x	
K			x	

REFRACTION

OD			X		ADD		20/	
OS			X		ADD		20/	

PRISM: OD B I/O OS B I/O ☐ N

OPTICAL ☐ **NO CORRECTION NEEDED**

☐ No SPRX given due to:

☐ Cataract ☐ Retina ☐ Other ____________

☐ **PROCEED TO OPTICAL**

☐ SV ☐ BF ☐ READERS ONLY +

☐ Current RX (within 12 months) Confirmed

ASSESSMENT

☐ RX WRITTEN: Complete section on page 1.

PRESSURE ☐ TP ☐ TA ☐ REFUSED ☐ SOFT PALPATION ☐ OTHER:

OD OS Time: AM PM Tech Initials:

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

GONIO

I	S	N	T

☐ Open on SLE Grade: ☐ Suspect Occludable on SLE (ANA)

DILATION ☐ CONTRAINDICATED ☐ REFUSED

PD M.5% M1 N1 N2.5% TIME: _______ READY: _______

SLIT LAMP ANTERIOR ☐ ALL STRUCTURES WNL

FINDINGS (Please Print Clearly):

SLIT LAMP POSTERIOR ☐ ALL STRUCTURES WNL

FINDINGS (Please Print Clearly): **ONH** **ONH**

C/D: OD X OS X ☐ OCT

OCT INTERPRETATION ☐ ONH ☐ MAC ☐ RETINA ☐ Other __________

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.

SAMPLE

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.

PLACE PATIENT LABEL AT FRAME CHECK OUT	**LENS DESIGN:** ☐ Single Vision ☐ Bifocal (FT-28)	
	LENS MATERIAL: ☐ 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
	☐ Only 1 PD Measurement			☐ Only 1 PD Measurement	
FRAME INFORMATION	☐ Metal ☐ Plastic		Brand/Style Name:		
	Color:		_____ _____ ☐ ______ _____ _____ _____ _____ Eye Size Bridge Size Temple		

PLACE PATIENT LABEL AT FRAME CHECK OUT	**LENS DESIGN:** ☐ Single Vision ☐ Bifocal (FT-28)	
	LENS MATERIAL: ☐ 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
	☐ Only 1 PD Measurement			☐ Only 1 PD Measurement	
FRAME INFORMATION	☐ Metal ☐ Plastic		Brand/Style Name:		
	Color:		_____ _____ ☐ ______ _____ _____ _____ _____ Eye Size Bridge Size Temple		

SAMPLE