2025 SEATTLE/KING COUNTY CLINIC
PATIENT VISION RECORD

PATIENT LABEL REQUIRED

PLACE PATIENT LABEL IN THIS BOX

	COMPLETED VISION SERVICES	QTY	PROVIDER/TECH NAME (Please Print)
□	**Pre-Testing**	**1**	
□	**Refraction**	**1**	
□	**Dilation**	**1**	
□	**Slit Lamp**	**1**	
□	**OCT**	**1**	
□	**Readers Dispensed**		
□	**Single Vision Ordered**		
□	**Bifocals Ordered**		

Does patient have with them an official SPRX written in the last 24 months AND do they want to skip the eye exam?

□ No, patient routed to **Vision Triage Waiting Area** □ Yes, patient routed to **Optical Waiting Area**

VISION TRIAGE Date of Last Eye Exam: Wear Glasses: □ Yes □ No Wear Contacts: □ Yes □ No

Chief Complaint:

□ Comprehensive Exam: Updated eyeglasses prescription and health check

□ Address a specific concern:

□ Other:

DIRECTOR AUTHORIZATION

□ FIN SVC: SERVICE: DATE:

□ EMG REF: EMG REF DX: □ Cataracts □ Diabetic Ret. □ Glaucoma □ Maculopathy □ Other:

VISION TRIAGE

Common Symptoms:

□ Discomfort
- □ Burning
- □ Discharge / Flaking
- □ Dryness
- □ Itching
- □ Redness
- □ Stinging
- □ Watering

□ Blurred Vision
- □ All Distances
- □ Distance
- □ Intermediate (Computer)
- □ Near (Reading)

□ Glare / Difficulty Driving at Night

□ Flashes

□ Floaters

□ Headaches

Uncommon Symptoms:

□ Double Vision

□ Muscle Weakness

□ New Confusion

□ Obstructed Vision (Shade or Veil)

□ Recent Fevers

□ Scalp Tenderness

□ Transient or Frank Vision Loss

□ Unusual Fatigue

Family History: □ Blindness □ Glaucoma □ Macular Degeneration □ Retinal Detachment

Ocular History:

□ Blood Transfusions

□ Cataract Surgery

□ Floater Removal / Wrinkle Peel

□ Glaucoma Surgery

□ Injections

□ Keratoconus

□ Laser Surgery (LPI, SLT, YAG)

□ Lid or Eye Muscle Sx

□ Long-Term Steroid Use

□ Refractive Surgery (LASIK / PRK / SMILE / RK)

□ Retinal Hole / Tear / Detachment

□ Transplant

□ Other

Prescription: Transcribe Written Rx, Quantity & Dosage

Provider Name (Print): **Date:**

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	

MANIFEST PLEASE WRITE CLEARLY

	Sph	Cyl	Axis	Add	Prism	BCVA
OD						20/
OS						20/

FINAL REFRACTION PLEASE WRITE CLEARLY

	Sph	Cyl	Axis	Add	Prism	BCVA
OD						20/
OS						20/

OPTICAL **□ NO CORRECTION NEEDED**

□ No SPRX given due to:

□ PROCEED TO OPTICAL

□ SV □ BF □ READERS ONLY +

□ Other

ASSESSMENT

□ RX WRITTEN: Complete section on page 2.

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)

DILATION □ CONTRAINDICATED □ REFUSED

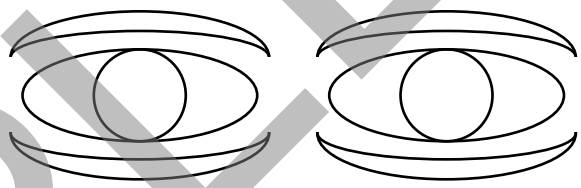
PD M.5% M1 N1 N2.5% TIME: _____ READY: _____

FLOW □ NEEDS SLIT LAMP □ SKIP DILATION: GO TO OPTICAL

□ FINISH DILATION: RETURN TO SLIT LAMP

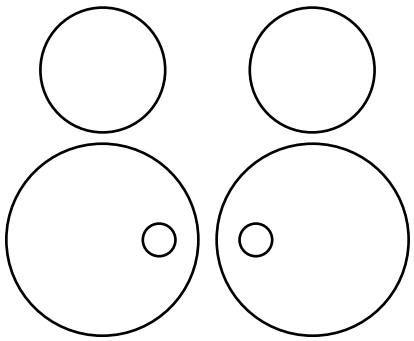
SLIT LAMP ANTERIOR □ALL STRUCTURES WNL

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 _____

RNFL OD _____

RNFL OS _____

CMT OD _____

CMT OS _____

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.

2025 SEATTLE/KING COUNTY CLINIC
PRESCRIPTION EYEGLASSES ORDER FORM

Patient Name (as printed on label): _____ Patient ID# (as printed on label) P_____

PATIENT ACKNOWLEDGEMENT OF EYEGLASSES ORDER:

My prescription eyeglasses 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

Readers: □ (+1.0) □ (+1.5) □ (+2.0) □ (+2.5) □ (+3.0) □ (+3.5)

Patient Signature:

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 CHECKOUT

PAIR 1

LENS DESIGN: □ Single Vision □ Bifocal

LENS MATERIAL: □ Polycarbonate **SO:**

EYE	SPHERE	CYLINDER	AXIS	ADD	PRISM	SEG / OC
RIGHT (OD):						
LEFT (OS):						
DISTANCE PD	RE/OD	LE/OS	NEAR PD FOR BIFOCALS	RE/OD	LE/OS	
FRAME INFORMATION	□ Metal Edge □ Zyl (Plastic) Edge		Brand/Style Name:			
	Color:		_____ _____ □ _____ _____ _____ _____ _____ Eye Size Bridge Size Temple			
DIAG	□ ARMD □ DM □ GLC □ LOW					

PLACE PATIENT LABEL AT FRAME CHECKOUT

PAIR 2

LENS DESIGN: □ Single Vision □ Bifocal **Director Auth:**

LENS MATERIAL: □ Polycarbonate **SO:**

EYE	SPHERE	CYLINDER	AXIS	ADD	PRISM	SEG / OC
RIGHT (OD):						
LEFT (OS):						
DISTANCE PD	RE/OD	LE/OS	NEAR PD FOR BIFOCALS	RE/OD	LE/OS	
FRAME INFORMATION	□ Metal Edge □ Zyl (Plastic) Edge		Brand/Style Name:			
	Color:		_____ _____ □ _____ _____ _____ _____ _____ Eye Size Bridge Size Temple			
DIAG	□ ARMD □ DM □ GLC □ LOW					

Patient's mailing and email address MUST be confirmed at Vision Checkout. Address Confirmed: _____ Address Changed: _____