2026 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	
☐	Dialation	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

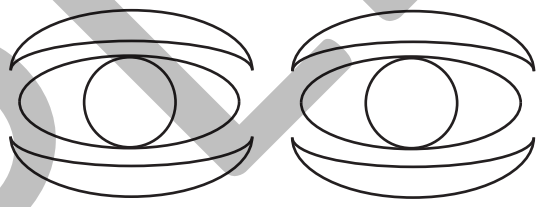
PD M.5% M1 N1 N2.5% TIME: _____ READY: _____

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

☐ FINISH DILATION: RETURN TO SLIT LAMP

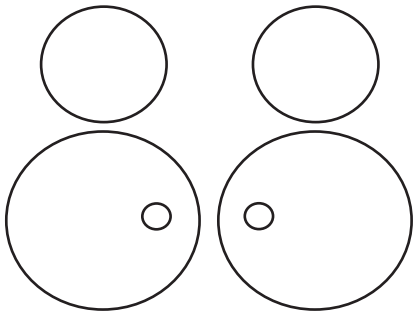
SLIT LAMP ANTERIOR ☐ ALL STRUCTURES WNL

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 and print your name.

2026 SEATTLE/KING COUNTY CLINIC
PRESCRIPTION EYEGLASSES ORDER FORM

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

PATIENT ACKNOWLEDGMENT 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 CHECK OUT

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 CHECK OUT

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: _____