



EYE CENTERS OF SOUTH FLORIDA

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**EXTERN ORIENTATION PACKET 2
CLINICAL & OTHER PROTOCOLS**

**Extern Group 101
Summer Quarter
Class of 2022**

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 2. Bill Trattler, MD
 3. Matthew Kay, MD (NSU only)
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FOR FRONT DESK: Is patient (and guest) wearing a mask? Yes, No. If not, offer a mask. Mask accepted Yes No

 Yes No

If yes, where _____

If yes, date(s) tested	Results	positive	negative
------------------------	---------	----------	----------

If yes, date(s) tested	Results	positive	negative
------------------------	---------	----------	----------

If yes, date(s)

12. Were you hospitalized due to COVID-19?	Yes	No
--	-----	----

If yes, date(s) _____

Name: _____ Today's Date: _____

Signature: _____

For Office Use Only

Patient / Guest wearing Face Mask ___ Yes ___ No Patient / Guest Sanitized or Washed Hands ___ Yes ___ No

Forehead Temperature recorded: _____ Time: _____ AM / PM Forehead contact Infrared

Temperature in Normal range ☐ Yes ☐ No. Recheck Temp: _____

Note: If temperature above 99.4 after recheck, Notify the doctor immediately

Screening answers ☐ Pass ☐ Fail (If FAIL, Notify the doctor immediately)

Checked & Reviewed by: _____ Physician Signature: _____

Once completed, place on side D under today's exam notes.

EYE CENTERS OF SOUTH FLORIDA (C to D) Yellow NAME: _____

COVID-19 SCREENING QUESTIONNAIRE (rev.4/27/21) DOB: _____ CHART#: _____

EYE CENTERS OF SOUTH FLORIDA
Dan & Hoffman, M.D.'s, P.A.

Dear Patients and Friends,

The safety and security of our patients, families, caregivers and visitors is our top priority. This includes ensuring that we maintain a COVID-19 safe environment for everyone who enters our offices. We have implemented many processes to provide the safest environment for our patients, caregivers and physicians in response to COVID-19.

Enhanced Screening

- We are screening everyone for COVID-19 before they enter our offices through daily temperature, signs and symptoms checks.

Masks for All Visitors

- Everyone who enters our offices will be required to wear a mask or facial covering. If you have a mask at home, please wear it to your visit. Otherwise, we will provide one for you and your visitor to wear throughout your stay.

Infection Prevention

- Hand hygiene is always a priority for us. Hand sanitizer and handwashing stations are available throughout our offices.
- We have removed frequently touched items such as magazines, toys, vending machines, coffee and snacks.

Heightened Disinfection

- We have increased the cleaning frequency of patient rooms, public and common areas, restrooms, waiting areas and any commonly touched surfaces.
- Strict infection control practices remain in place including cleaning and sterilizing equipment, cleaning and disinfecting patient care areas and terminal cleaning of the operating room after each surgery.
- Our disinfectants are effective in killing the virus that causes COVID-19 and other pathogens.

Personal Protective Equipment for Colleagues

- We have an adequate supply of PPE for all of our clinical staff and physicians. This helps protect you and our team from COVID-19 transmission.

Enhanced Patient Safety Policy

- We are adhering to social distancing, and our lobby is marked, so you will know where to stand and sit. This will also be factored in throughout all phases of care during your stay. If you prefer to wait in your car, please feel free to do so.
- To reduce overall exposure, we are currently limiting visitors to one per patient. For pediatric patients, two visitors (close relatives) may come to the offices. Please do not come more than 10 minutes prior to your appointment.

Following Safety Protocols

- We are following Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS) and appropriate state guidelines for performing COVID-19 safe surgeries.

We are committed to providing the highest level of healthcare for each of our patients and ensuring that you remain safe at all times. Please feel free to reach out to us should you have any questions about your procedure. Thank you for entrusting us with your care. We are privileged to serve you.

Sincerely,
The Eye Care Team
Eye Centers of South Florida

NEW PATIENT EXAM PROTOCOL

1. EYE HISTORY

- c. Review the new patient eye history form and EYE medication record with the patient.
- d. Elicit the primary reason for the patient's visit as the chief complaint
- e. and extended history of present history.
- f. Sign the bottom of the page.
- g. IF PATIENT HAS A RED EYE, SEE RED EYE PROTOCOL CHECKLIST.

2. MEDICAL HISTORY

- a. Review the new patient MEDICAL history form and ORAL medication record with the patient.
- b. Sign the bottom of the page.

3. ACUITIES/ AMSLER

- a. Distance and near with correction.
- b. Pinhole if acuities are less than 20/30.
- c. Perform Amsler grid test if near VA is worse than J1 or near complaints.
- d. Perform BAT or auto refractor glare test on cataract patients with acuity 20/25 to 20/40.

4. NEURO-OPHTHALMIC

- a. Pupils,
- b. motility, and
- c. confrontation fields.

5. COLOR VISION

- a. Ishihara
- b. All new patients 25 years old or less.

6. STEREO ACUITY-

- a. For children.
- b. Rondot E
- c. StereoFI

7. AUTO-REFRACTOR / KERATOMETER

- a. tape printout strip to the back of NP Medical History form

8. AUTO-LENSOMETER

- a. Check patient's most frequently used glasses;
- b. describe frame if more than one pair.
- c. tape printout strip to the back of NP Medical History form

9. CORNEAL TOPOGRAPHY-

- a. Perform on patients with keratoconus, high astigmatism,
- b. unexplained visual loss
- c. pterygia
- d. s/p refractive surgery or refractive surgery candidates
- e. if recommending refractive cataract surgery.

10. REFRACTION-

- a. On the Eye History Form, patients indicate if a refraction is desired;
- b. it's preferred NOT to refract an optometry referred patient,
- c. except *if referred by an OD for cataract evaluation, perform a QUICK diagnostic refraction.
- d. See REFRACTION FAQs
- e. CIRCLE Refraction on Superbil
- f. FILL out eyeglass prescription

11. TONOMETRY-

- a. Routine: Perform goldmann applanation
- b. Special: patient is wheelchair bound, or physical limitations, then use the Tonopen or iCare.
- c. Infection: Tonopen for patients with red eyes / infections. infectious, HIV+, hepatitis
- d. see **Tonopen and Icare Tonometer Indications for Use** (in Important Checklists & Protocols)

12. SLIT LAMP EXAMINATION

- a. - Record findings.
- b. Check angles.

13. GONIOSCOPY

- a. 4 MIRROR without flange
- b. Perform gonioscopy on glaucoma or suspect, narrow angles, or $> +3.00$ D.

14. DILATION-

- a. Routine: Patients should be dilated with Paremyd or Tropicamide;
 - b. Flashes and Floaters: if a patient dilates poorly or has possible peripheral retinal pathology, then use tropicamide and phenylephrine can be added.
 - c. Record eye dilated, med used and time of dilation
 - d. RECORD POST DILATION PUPIL SIZE.
 - e. Tell patient dilation takes 30 minutes
 - f. See DILATION FAQs
15. FUNDUS EXAMINATION
- a. 90D OR 78D
 - b. 20D OR 28D
16. PACHYMETRY.
- a. Pachymetry Form
 - b. Pachymeter
17. SCHIRMER TEAR TEST-
- a. Perform if patients have DES symptoms or positive responses on eye history form.
 - b. Schirmer form
18. VISUAL FIELD-
- a. FDT screening (30-2).
 - b. FDT Screening Form
19. ANTERIOR SEGMENT PHOTOGRAPHY
- a. Slit Lamp Photography
 - i. Exam room 10 NMB
 - ii. Smartphone attachments on any slit lamps
 - iii. perform on anyone with any interesting cornea finding/pathology
 - b. iCamera Photography
 - i. use for any eyelid abnormalities
 - ii. see **External Photography Protocol** (in Important Checklists & Protocols)
 - c. Visucam Photography
 - i. use for Pterygia
20. OCT- (Cirrus OCT)
- a. Optic Nerve:
 - i. Glaucoma/glaucoma suspect/ narrow angles/
 - ii. optic neuropathy
 - iii. papilledema
 - b. Macula:
 - i. AMD and
 - ii. other retinal conditions.
 - iii. Plaquenil Screening
 - c.
21. FUNDUS PHOTOGRAPHY
- a. VISUCAM Fundus Camera
 - i. baseline fundus and disc photos, montage on diabetics,
 - ii. take anterior segment photo on patients with pterygium.
 - b. Canon Fundus camera
 - i. FAF fundus photos

***CIRCLE ABNORMAL FINDINGS IN RED**

NEW PATIENT EYE HISTORY RECORD

Today's Date: _____ This Form is Completed By: ☐ Myself ☐ Other: _____

Who Recommended us or Referred you to our office?

Reason(s) for Today's Visit: ☐ Comprehensive Eye Evaluation
☐ Cataracts ☐ Contacts ☐ Cornea ☐ Glaucoma ☐ Diabetes
☐ Double Vision ☐ Dry Eye ☐ Eyelids ☐ Floaters ☐ Infection
☐ LASER ☐ Macular Degeneration ☐ Pain ☐ Red Eye ☐ Retina
☐ Style(s) ☐ Tearing ☐ Vision Problem ☐ Other: _____

Do you have Visual Difficulties or Disturbances? ☐ No ☐ Yes:

☐ Driving in Daytime ☐ Driving at Night ☐ Reading Small Print
☐ Computer Work ☐ Watching TV ☐ Night Vision Adaptation
☐ Seeing steps, stairs or curbs ☐ Other: _____

Do you have any Eye Symptoms? ☐ No ☐ Yes:

☐ Burning ☐ Dry ☐ Irritation ☐ Itching ☐ Red ☐ Discomfort
☐ Light Sensitivity ☐ Gritty/Sandy Feeling ☐ Eye Pain or Soreness
☐ Other: _____

Have you ever had your Eyes Checked? ☐ No ☐ Yes;

☐ Optometrist: _____

City: _____ Phone: _____

Date First Seen: _____ Date Last Seen: _____

☐ Ophthalmologist: _____

City: _____ Phone: _____

Date First Seen: _____ Date Last Seen: _____

Do you Wear Eyeglasses? ☐ No ☐ Yes; How old are they? _____

Are your Eyeglasses for: ☐ Distance ☐ Reading ☐ Computer

Are you pleased with your Eyeglasses? ☐ Yes ☐ No

Where do you get your glasses? _____

Do you wear Contact Lenses? ☐ No ☐ Yes;

Are your Contacts Replaced: ☐ Daily ☐ Bi-Weekly ☐ _____

Are you pleased with your Contact Lenses? ☐ Yes ☐ No;

Where do you get your contacts? _____

Are you satisfied with your current vision? ☐ Yes ☐ No

Do you use any Eye Medications or Eye Drops? ☐ No ☐ Yes:

List Names, Dosage and Directions (which eye and how often)

Have you had any Eye Problems or Injuries? ☐ No ☐ Yes:

Please List Problems, Date of onset and Eye Doctor seen

Have you ever had any Eye Operations? ☐ No ☐ Yes:

List Operations, Date(s) performed and Eye Surgeon's Name

Have you ever had a diagnosis of Lazy Eye? ☐ No ☐ Yes:

How would you describe your Eye (iris) Color? ☐ Amber ☐ Blue

☐ Brown ☐ Gray ☐ Green ☐ Hazel ☐ Other: _____

Is there a Family History of Eye Problems? ☐ No ☐ Yes;

Please Check all applicable and indicate family relationship:

(M = Mother F = Father S = Sibling GP = Grand Parent)

☐ Blindness ☐ Cataracts ☐ Retinal Detachment

☐ Diabetes ☐ Glaucoma ☐ Macular Degeneration

☐ Lazy Eye ☐ Other: _____

How would you describe your Eye Health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

-----Do Not Write Below This Line-----

Please review above for completeness and obtain additional history as needed.

CC: _____

HPI: _____

_____ (over)

OSP/OA/OT Name: _____ MD/DO/OD Sig _____

NEW PATIENT MEDICAL HISTORY RECORD

Today's Date: _____ Form Completed By: ___Self___ Other: _____

LAST MEDICAL CHECK-UP? ☐ This year ☐ Last year

☐ More than a year ago ☐ Don't remember ☐ Never

HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

HEIGHT: _____ **WEIGHT:** _____

Primary Physician _____

Specialty _____ Phone _____

Other Physician _____

Specialty _____ Phone _____

PAST MEDICAL HISTORY: Please list any medical conditions you have or had, date of onset or duration and doctor's name:

1. _____

Date: _____ Doctor: _____

2. _____

Date: _____ Doctor: _____

3. _____

Date: _____ Doctor: _____

PAST SURGICAL HISTORY (Not Eye Surgeries): Please list any surgeries or procedures performed, dates and doctor's name:

1. _____

Date: _____ Doctor: _____

2. _____

Date: _____ Doctor: _____

3. _____

Date: _____ Doctor: _____

HAVE YOU HAD THE SHINGLES VACCINE?

☐ No ☐ Yes: ☐ Zostavax ☐ Shingrix Date _____

OTHER MEDICATIONS: Do you take any medications, vitamins or supplements? ☐ No ☐ Yes; List names, dose and frequency or attach a copy of your medication list if you have one.

1. _____

2. _____

3. _____

4. _____

5. _____

ALLERGIES: ☐ No Known Allergies ☐ Yes; (check below)

☐ Aspirin ☐ Codeine ☐ Ibuprofen ☐ Iodine

☐ IV contrast ☐ Neomycin ☐ Penicillin ☐ Sulfa

☐ Airborne _____ ☐ Contact _____

☐ Food _____ ☐ Other _____

REVIEW OF SYSTEMS: Do you have any problems in the following areas? If Yes, please specify.

Ear, Nose & Throat. ☐ No ☐ Yes _____

Cardiovascular ☐ No ☐ Yes _____

Respiratory ☐ No ☐ Yes _____

Gastro-Intestinal ☐ No ☐ Yes _____

Urinary ☐ No ☐ Yes _____

Skin ☐ No ☐ Yes _____

Muscle ☐ No ☐ Yes _____

Neurological ☐ No ☐ Yes _____

Psychiatric ☐ No ☐ Yes _____

Rheumatologic ☐ No ☐ Yes _____

Hearing loss / aids ☐ No ☐ Yes _____

Disability* ☐ No ☐ Yes _____

SOCIAL / PERSONAL HISTORY:

Primary Language Spoken: English Spanish French Creole

Russian Italian Portuguese Other _____

Country of Origin: _____

Work History: Employed Unemployed Retired Homemaker

Current or Previous Occupation: _____

School History: No Yes: Full Time Part Time

Marital Status: Single Married Divorced Widowed Separated

Do you drive? ☐ Yes ☐ No _____

Living At: Home Assisted Living Nursing Home Away/College

Living With: Self Spouse Family Parents Roommate Other

Tobacco Use: No Yes: ___ packs/day Quit: ___ yrs ago

Alcohol Use: No Yes: ___ drinks/day Quit: ___ yrs ago

-----Do Not Write Below This Line-----

Please review above for completeness and obtain additional history as needed.

OD _____ MD _____

EYE CENTERS OF SOUTH FLORIDA (10/15/18) [D]

NEW PATIENT MEDICAL HISTORY RECORD

NAME: _____

D.O.B: _____ CHART#: _____

NEW PATIENT EYE EXAM RECORD (1)

DATE _____ AGE _____ SEX _____

GENERAL NEUROLOGICAL / PSYCHOLOGICAL

☐ Awake, Alert & Oriented X 3 debilitated somnolent disoriented
☐ Mood and Affect Appropriate worried anxious agitated somber

VISUAL FUNCTION

DVA: cc / CL sc ph BAT/VAT. **NVA** cc / CL sc
 OD: 20/____ 20/____ 20/____ 20/____ OD: J ____ J ____
 OS: 20/____ 20/____ 20/____ 20/____ OS: J ____ J ____
 OU: 20/____ 20/____ * Always measure each eye individually first

OPTICAL : ☐ None ☐ Glasses ☐ Contact Lenses: SCL RGP HCL OK

GLASSES 1: DV / IV / NV / BIF / TRI / PAL **GLASSES 2:** DV / IV / NV / BIF / TRI / PAL

OD _____ OD _____

OS _____ OS _____

ADD _____ Rx Date? _____ ADD _____ Rx Date? _____

AUTO REFRACTION: ☐ Dilated VA: Glare VA:

OD _____ 20/____ 20/____

OS _____ 20/____ 20/____

KERATOMETRY: ☐ Auto ☐ Manual: Exam Room # _____

OD H _____ X _____ / V _____ X _____ Mires _____

OS H _____ X _____ / V _____ X _____ Mires _____

REFRACTION: ☐ Diagnostic ☐ Manifest ☐ 92015 DVA: Near VA:

OD _____ 20/____ J _____

OS _____ 20/____ J _____

ADD: + _____ OU SRX REC: N Y ? OU 20/____ ☐ TF D N

CONFRONTATION FIELDS

OD: ☐ Normal ☐ Abnormal _____ OD: ☐ Normal ☐ Abnormal _____

OS: ☐ Normal ☐ Abnormal _____ OD: ☐ Normal ☐ Abnormal _____

OCULAR MOTILITY

☐ Normal **PHORIAS** ☐ Normal

OD _____ Dist: H _____ V _____

OS _____ Near: H _____ V _____

PUPILS AND IRIS ☐ Normal equal, _____ mm OU ☐ Abnormal

OD: Size (D/B): _____ mm Shape: _____ Reaction: _____ APD: _____

OS: Size (D/B): _____ mm Shape: _____ Reaction: _____ APD: _____

☐ COLOR: _____ ☐ STEREO: _____

☐ P.A.M: _____ ☐ HERTEL: _____

☐ Other: _____

ADNEXA /FACE _____

EXTERNAL: **OD**

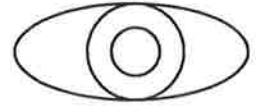
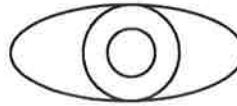
- Lids Dermatochalasis Ptosis
 Entropion Ectropion
 - Lac. gland Prolapse
 - Puncta Everted
 - Orbits Deep Proptosis

Normal

NL
 NL
 NL
 NL
 NL

OS

Dermatochalasis Ptosis
 Entropion Ectropion
 Prolapse
 Everted
 Deep Proptosis



EP 92285

SLIT LAMP: **OD**

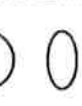
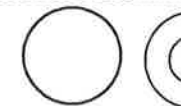
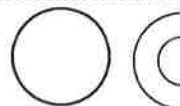
-EyeLid Margins
 -Anterior Blepharitis
 -Vascularization
 -Posterior Blepharitis
 -Puncta stenosis
 -Conj. inj CC conc.
 -Cornea arcus ABMD scar
 -Tear Film dry x/s mucoid
 -Epithelium PEE
 -Stroma thick cloudy edema
 -Endothelium guttata
 -AC +C/ +F
 -Angles Narrow
 -Iris PRA PI
 -Lens NS CC PSC
 -IOL PCL ACL ISL
 -IOL Type CSTL MTF Toric
 -PC +Opacification Open Intact & Clear

Normal

WNL
 4 3 2 1 0 1 2 3 4
 4 3 2 1 0 1 2 3 4
 4 3 2 1 0 1 2 3 4
 Patent
 W&Q
 WNL
 WNL
 Clear
 Clear
 D & Q
 Open
 WNL
 Clear
 Center
 Std

OS

stenosis
 inj CC conc.
 arcus ABMD scar
 dry x/s mucoid
 PEE
 thick cloudy edema
 guttata
 +C/ +F
 Narrow
 PRA PI
 NS CC PSC
 PCL ACL ISL
 CSTL MTF Toric
 +Opacification Open



Cornea

Lens

Cornea

Lens

☐ **TEAR BREAK-UP TIME:** OD _____ sec OS _____ sec

☐ **SCHIRMER TEST:** OD _____ mm OS _____ mm

TENSION (GAT) _____ AM/PM **ICARE Tonometer (i)** **TONOPEN (T)**

OD _____ mmHg PCF _____ OD _____ OD _____

OS _____ mmHg PCF _____ OS _____ OS _____

GONIO



Open



92020

Grade: 0 1 2 3 4

Grade: 0 1 2 3 4

☐ **DILATED** OD OS OU w/ P2.5 PRM T1 C1 @: _____ AM/PM

☐ NOT DILATED (reason): _____

☐ **FDT VISUAL FIELD (92082)** _____

☐ **PACHYMETRY (76514):** CCT OD _____ OS _____

OSD/OD/OT _____ Room # _____

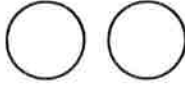
EYE CENTERS OF SOUTH FLORIDA (01/17/20) W2HP NAME: _____

NEW PATIENT EYE EXAM RECORD (1) [D] Rev. 27 D.O.B: _____ CHART#: _____

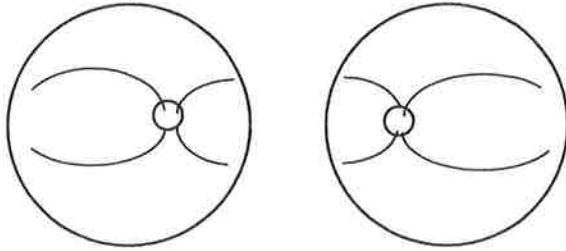
NEW PATIENT EYE EXAM RECORD (2)

FUNDUS:	OD	Normal	OS
-VIT	Floaters PVD Syneresis	Clear	Floaters PVD Syneresis
-D	C/D: 0.____ PPA	Pink	C/D: 0.____ PPA
-V	AN NPDR PDR VE	NL	AN NPDR PDR VE
-M	CME DME Drusen ERM RPE	Flat	CME DME Drusen ERM RPE
-P	Lattice Hole Tear Scar	NL	Lattice Hole Tear Scar

- ☐ 92201 Retina
☐ 92202 ON/Mac



90D
20D
28D
CL
SD



*Pupil Size after Dilation: OD: _____ mm OS: _____ mm

DIAGNOSTIC IMPRESSION

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PATIENT INFORMATION & INSTRUCTIONS

- ____ Diagnosis / Treatment Information Sheet(s) given
 ____ Medication Instruction Sheet(s) given
 ____ Diagnosis, Prognosis and Treatment discussed w/ Patient & Family
 ____ Alternatives, Benefits and Risks of Planned Procedure discussed
 ____ Other: _____

CORRESPONDENCE / NEED

- ____ Fax Consultation Report Form to Referring Doctor and/or PCP
 ____ Request Prior Records: _____
 ____ Request Prior Authorization: _____

ADDITIONAL EXAMINATION AND DIAGNOSTIC SERVICES

- | | |
|---|--|
| <input type="checkbox"/> External Photography (92285) | <input type="checkbox"/> Fundus Photography (92250) |
| <input type="checkbox"/> OCT Macula (92135) | <input type="checkbox"/> OCT ON RNFL (92135) |
| <input type="checkbox"/> HRT Optic Nerve (92135) | <input type="checkbox"/> 2X Disc Photography (92250) |
| <input type="checkbox"/> Corneal Topography (92025) | <input type="checkbox"/> Specular Microscopy (92286) |
| <input type="checkbox"/> A-Scan (76519) | <input type="checkbox"/> B-Scan (76512) |
| <input type="checkbox"/> IOL Master (92136) | <input type="checkbox"/> Humphrey Field (92081-2-3) |
| <input type="checkbox"/> Serial Tonometry (92100) | <input type="checkbox"/> Fluorescein Angiography |
| <input type="checkbox"/> InflammDry (83516QW) | <input type="checkbox"/> RPS Adenodetector (87809QW) |
| <input type="checkbox"/> Other: _____ | |

MANAGEMENT PLAN AND/OR RECOMMENDATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

FOLLOW-UP

Return to Office: ____D ____W ____M ____ PRN ____D/C

Next Visit: (Nature of Visit: FU LZ MS PO SR LR WU)

Dilate Refraction VF OCT-O OCT-M OCT-AS InflammDry B-Scan

LZ: ALT LPI YAG L PC MS: Chalazion Eyelid Other

WU: Cataract Dry Eye Glaucoma Tearing

OS/OT Name: _____ Scribe Name: _____

Physician Signature: _____

Doctor: Hoffman Sarraga Taher Williams

EYE CENTERS OF SOUTH FLORIDA (01/17/20) W/2HP NAME: _____

NEW PATIENT EYE EXAM RECORD (2) [D] Rev. 27 D.O.B: _____ CHART#: _____

ESTABLISHED PATIENT EXAM

1. EYE HISTORY
 - c. Determine the reason for patient's visit, (i.e. 3 month glaucoma check, non-routine visit for specific complaint,..., the first line of the history should indicate when the patient was told to return for their next visit (*as noted on the bottom of the last exam notes*), and then when the patient actually came back. SEE SAMPLE on next page.
 - d. Elicit if the patient notes any changes with vision or ocular health.
 - e. Check ocular meds and write prescription if on any chronic medication.
 - f. Update Problem List Sheet
 - g. Update Medication Record
 - h. Check off on testing summary box on bottom of exam form.
2. IF PATIENT HAS A RED EYE, SEE RED EYE PROTOCOL CHECKLIST.
3. ACUITIES/ AMSLER
 - a. Distance with correction.
 - b. Near with correction every 6 months or if patient has complaints of decreased vision..
 - c. Pinhole if acuities are less than 20/30.
 - d. Perform Amsler grid test if near complaints.
 - e. Perform BAT or auto refractor glare test on cataract patients with acuity 20/25 to 20/40.
4. NEURO-OPHTHALMIC
 - a. Pupils, **EVERY 6 MONTHS or if new neurological complaints.**
 - b. motility, **EVERY 6 MONTHS or if new neurological complaints.**
 - c. confrontation fields, **EVERY 6 MONTHS or if new neurological complaints.**
5. AUTO-REFRACTOR / KERATOMETER
 - a. perform if patient wants a refraction and the last refraction is more than 1 year
 - b. perform if the patient is 1 week or 4 week post-op
 - c. perform if there is a big change in vision or new visual complaints ALWAYS measure the glasses prescription if a refraction was done; check patient's most frequently used glasses; describe frame if more than one pair. (tape printout strips on back of exam form)
 - d. tape printout strip to the back of exam form
6. AUTO-LENSOMETER
 - a. measure glasses if refraction was done
 - b. check patient's most frequently used glasses;
 - c. describe frame if more than one pair.
 - d. tape printout strip to the back of exam form
7. CORNEAL TOPOGRAPHY-
 - a. Perform on patients with keratoconus, high astigmatism, pterygia, s/p refractive surgery once per year
 - b. unexplained visual loss
 - c. if recommending refractive cataract surgery.
8. REFRACTION-
 - a. If new visual complaints
 - b. patient's request (see REFRACTION FAQs)
 - c. 4 week post-operative cataract surgery
 - d. **if considering cataract surgery, perform a QUICK diagnostic refraction*
 - e. it's preferred NOT to refract an optometry referred patient, except *if referred by an OD for cataract evaluation, perform a QUICK diagnostic refraction.
 - f. See REFRACTION FAQs
 - g. CIRCLE Refraction on Superbill
 - h. FILL out eyeglass prescription
9. TONOMETRY-
 - a. Routine: Perform goldmann applanation
 - b. Special: patient is wheelchair bound, or physical limitations, then use the Tonopen or iCare.
 - c. Infection: Tonopen for patients with red eyes / infections. infectious, HIV+, hepatitis
 - d. see **Tonopen and Icare Tonometer Indications for Use** (in Important Checklists & Protocols)
10. SLIT LAMP EXAMINATION
 - a. Record findings.
 - b. Check angles.
11. GONIOSCOPY
 - a. 4 MIRROR without flange

- b. Perform gonioscopy on glaucoma or suspect once per year
 - c. narrow angles
- 12. DILATION-
 - a. Patients without retinal conditions or glaucoma, dilate annually
 - b. Patients with prior retinal/medical condition (AMD, diabetic, glaucoma, HIV+...), dilate EVERY SIX MONTHS
 - c. if patient presents with a problem that may indicate a new retinal condition
 - d. Patients should be dilated with Paremyd or Tropicamide;
 - e. If a patient dilates poorly or has possible peripheral retinal pathology, then use tropicamide and phenylephrine can be added.
 - f. Record eye dilated, med(s) used and time of dilation
 - g. RECORD POST DILATION PUPIL SIZE.
 - h. Tell patient dilation takes 30 minutes
 - i. See DILATION FAQs
- 13. FUNDUS EXAMINATION
 - a. 90D OR 78D
 - b. 20D OR 28D
- 14. PACHYMETRY.
 - a. Perform a second pachymetry 1 year after the initial measurement
 - b. Fuch's patients once every 6 months
 - c. Keratoconus patients once every 6 months
 - d. Use Pachymetry Form
- 15. SCHIRMER TEAR TEST-
 - a. Perform if patients have DES symptoms once, usually does not need to be repeated
 - b. Use Schirmer form for instructions and to records results, tape strips on form
- 16. VISUAL FIELD-
 - a. FDT screening (30-2), once per year on non-glaucoma patients.
 - b. FDT Screening Form
 - c. FDT Threshold or HVF 24-2 Sita Fast on most glaucoma patient
- 17. ANTERIOR SEGMENT PHOTOGRAPHY
 - a. Slit Lamp Photography
 - i. Exam room 10 NMB
 - ii. Smartphone attachments on any slit lamps
 - iii. perform on anyone with any interesting cornea finding/pathology
 - b. iCamera Photography
 - i. use for any eyelid abnormalities
 - ii. see External Photography Protocol
 - c. Visucam Photography
 - i. use for Pterygia
- 18. OCT- (Cirrus OCT)
 - a. Optic Nerve:
 - i. Glaucoma/glaucoma suspect/ narrow angles/
 - ii. optic neuropathy
 - iii. papilledema
 - b. Macula:
 - i. AMD
 - ii. Diabetics
 - iii. other retinal conditions.
 - iv. Plaquenil Screening
 - c.
- 19. FUNDUS PHOTOGRAPHY
 - a. VISUCAM Fundus Camera
 - i. fundus and disc photos, montage on diabetics once per year
 - ii. take anterior segment photo on patients with pterygium.
 - b. Canon Fundus camera
 - i. FAF fundus photos

***CIRCLE ABNORMAL FINDINGS IN RED**

ESTABLISHED PATIENTS HISTORY SAMPLE

On returning patients, the first line of the history should indicate when the patient was told to return for their next visit (as noted on the bottom of the last exam notes), and then when the patient actually came back. Do NOT rely on the Nature of Visit on the superbill for any of this information. **If the interval is more than twice, then circle in RED.** SEE SAMPLE BELOW.

Sample

DAN AND HOFFMAN MD PA
JOSEPH HOFFMAN MD
 1701 NE 164TH ST
 STE 200
 N MIAMI BEACH, FL 33162-4018
 305-947-0027
PATIENT: [REDACTED]
 Address: PO BOX 530832
 MIAMI, FL 33153-0832

Email: [REDACTED]
 Home/Work Ph: (305) 893-6193
 SSN: [REDACTED]
 Chart Number: [REDACTED]
 DOB/Age/Gen: [REDACTED] / 71 years / F

INSURANCE INFORMATION
 Acct Type: MEDICARE/MEDICARE SUPPLEMEN
 FLORIDA MEDICARE PART B
 Prim Payor: [REDACTED]
 Member ID: [REDACTED]
 Group Name/Num: [REDACTED]
 Sec Payer: [REDACTED]
 Acct/Ins/Pat Bal: \$0.00 / \$0.00 / \$0.00
 Ms Acct/Ins/Pat Bal: \$0.00 / \$0.00 / \$0.00
 Last Pmt Date/Amount: [REDACTED]
 Past Due Pat Bal: [REDACTED]
COMMENTS

APPOINTMENT INFORMATION
 Date of Serv/Enc Num: 06/20/2014/058F15
 Appt/Arrival Time: 10:30AM
 Nature of Visit: SR 3M
 Default LOC/PCP: NMB2 / JOSEPH HOFFMAN, MD
 Appt Provider: JOSEPH HOFFMAN, MD
 Appt Location: NMB OFFICE 1701
 Authorization Number: [REDACTED]
 Referring Physician: ALAN GROSSMAN, OD- T84023
 Referral Source: [REDACTED]
 Elig Checked/How? Yes/Electronic
 Last Appt/Co-pay: 03/14/2014 / \$0.00
 Dt Last Cancel/Reas: 09/13/2013 - PATIENT CANCELLED
 Last Diag Info: 365.01/250.00

CC/HPI: 3 mths @ 12 months - cataracts ou.

indicates when patient was told to return (found on last exam notes) when the patient actually came back (time elapsed since last visit)

Eye Meds: x nature of visit is not always correct

EXAMINATION ☐ Awake, Alert & Oriented X 3 ☐ Head & Neck Appropriate

EXTERNAL: OD No Change OS

- Lids

- Lacrimal

- Puncta

SLIT LAMP: OD No Change OS

LL	Bleph	MGD	Trichiasis	NL	Bleph	MGD	Trichiasis			
-C/S	inj	cc	conc	W&Q	inj	cc	conc			
-C	Arcus	+CG	+Edema	Clear	Arcus	+CG	+Edema			
AC	+C	+F		D&Q	+C	+F				
Angles	0	1	2	3	4	0	1	2	3	4

On returning patients, the first line of the history should indicate when the patient was told to return for their next visit (as noted on the bottom of the last exam notes), and then when the patient actually came back. Do NOT rely on the Nature of Visit on the superbill for any of this information. This information should come from the patient's last notes. **If the interval is more than twice, then circle in RED.**

DAN HOFFMAN MD PA
JOSEPH HOFFMAN MD
1701 NE 164TH ST
STE 200
N MIAMI BEACH, FL 33162-4018
(305) 947-0027

PATIENT: [REDACTED]
Address: 19101 NE 18TH AVE
NORTH MIAMI BEACH, FL 33179-4214

Email: [REDACTED]
Home/Ph: 3053182718/ 3053182718
SSN: [REDACTED]
Chart Number: 209515
DOB/Age/Gen: [REDACTED] / 73 years / M

INSURANCE INFORMATION

Acct Type:
Prim Payer:
Member ID:
Sec Payer:
Acct/Ins Bal:
Ms Acct/Ins Bal:
Last Pmt Date/A
Past Due Pat Bal:
Pat Bal/Ms Pat B

MEDICARE HMO

\$0.00 / \$0.00
\$0.00 / \$0.00
\$0.00
\$0.00/\$0.00

APPOINTMENT INFORMATION

Date of Serv/Enc Nu 05/28/2020/453FDO
Appt/Arrival Time: 1:45PM
Nature of Visit: LR VF
Default LOC/PCP: NMBO / JOSEPH HOFFMAN, MD
Appt Provider: JOSEPH HOFFMAN, MD
Appt Location: NMB OFFICE 1701
Authorization Numbe
Referring Physician: JOSEPH HOFFMAN, MD- D67376
Other Phys 1/2:
Referral Source: FAMILY
Elig Checked/How?: Yes/Electronic
Last Appt/Co-pay: 03/19/2020 / \$0.00
Dt Last Cancel/Reas: 03/19/2020 - COVID-19
Last Diag Info: H25.13/H40.009/H11.009/E11.9

COMMENTS

CC/HPI: _____

Problem List Needs Update: ☐ No ☐ Yes ☐ Over

Eye Meds: _____

Eye Medication List Needs Update: ☐ No ☐ Yes ☐ Over

EXAMINATION ☐ Awake, Alert & Oriented X 3 ☐ Mood & Affect Appropriate

DVA: cc/ CL sc ph BAT / VAT NVA cc/ CL sc IVA: sc

OD 20/____ 20/____ 20/____ 20/____ OD J____ J____ J____

OS 20/____ 20/____ 20/____ 20/____ OS J____ J____ J____

OU 20/____ 20/____ @40cm @67cm

GLASSES 1: DV/IV/NV/BIF/TRI/PAL GLASSES 2: DV/IV/NV/BIF/TRI/PAL

OD _____ OS _____

OS _____

ADD: + _____ Rx Date: _____ ADD: + _____ Rx Date: _____

AUTO REFRACTION: ☐ Dilated ☐ VA: ☐ Glare VA: ☐

OD _____ 20/____ 20/____

OS _____ 20/____ 20/____

REFRACTION: ☐ Happy with current Rx ☐ 92015 DVA: NVA:

OD _____ 20/____ J____

OS _____ 20/____ J____

OU ADD: + _____ Rx Rec. N Y ? OU 20/____ ☐ TF D N

KERATOMETRY: ☐ Auto ☐ Manual (Exam Room _____) PHORIAS: ☐ WNL

OD H _____ x _____ / V _____ x _____ Dist: H _____ V _____

OS H _____ x _____ / V _____ x _____ Near: H _____ V _____

PUPILS: ☐ Normal ☐ Abnormal: OD _____ OS _____

ACCOMMODATION: ☐ Normal ☐ Abnormal: OD _____ OS _____

REFLEXES: ☐ Normal ☐ Abnormal: OD _____ OS _____

EXTERNAL: OD ☐ No Change OS ☐ 92285

Lids _____ Ptoxis _____ SL Photo _____

Lacrimal _____

Puncta _____ Ext Photo _____

Last Pach: _____ 2x Last FDT _____ Last HVF _____

Last 2XDP/FP: _____ Last OCT-ON: _____ Last OCT-Mac: _____

Last Gonio: _____ Last OCT-AS: _____ Last DFE: _____

*Circle Test Name if Test Needed Today and Perform Test or Circle if Needed Next Visit

COSF Established Patient Eye Exam Rev. 30 (01/17/2020) (W/2HP) (D)

SLIT LAMP: OD ☐ No Change OS

-LL Bleph MGD Trichiasis NL Bleph MGD Trichiasis

-C/S _____ Inj CC Ping Ptryg conc. W&Q _____ Inj CC Ping Ptryg conc.

-C Arcus ABMD CG _____ +Edema Clear Arcus ABMD CG _____ +Edema

AC _____ +C / _____ +F D&Q _____ +C / _____ +F

Angles 0 1 2 3 4 Open 0 1 2 3 4

-I Nevus NVI PRA PI NL Nevus NVI PRA PI

-L _____ NS _____ CC _____ PSC Clear _____ NS _____ CC _____ PSC

-IOL PCL ACL ISL Centered PCL ACL ISL

-IOL Type CSTL MTF Toric Std. CSTL MTF Toric

-PC _____ +Opacification Open Intact & Clear _____ +Opacification Open

TEAR BREAK-UP TIME: OD _____ sec OS _____ sec

SCHIRMER TEST: OD _____ mm OS _____ mm

TENSION (GAT) _____ AM/PM ICARE tonometer (i) TONOPEN (T)

OD _____ mm Hg PCF _____ OD _____ OS _____

OS _____ mm Hg PCF _____ OS _____ OS _____

GONIOSCOPY: OD 0 1 2 3 4 OS 0 1 2 3 4 ☐ 92020

DILATED: OU OD OS w/ P2.5 T1 PRM C1@ _____ AM/PM ☐ Declines

FUNDUS: OD ☐ No Change OS

-VIT Cell Heme Pig PVD Clear Cell Heme Pig PVD

-D C/D: 0. _____ PPA Pink C/D: 0. _____ PPA

-V AN NPDR PDR VE NL AN NPDR PDR VE

-M CME DME Drusen ERM RPE Flat CME DME Drusen ERM RPE

-P Lattice Hole Tear Scar NL Lattice Hole Tear Scar

☐ OCT MAC ☐ OCT NFL ☐ FUNDUS

90D   

20D

360

SD ☐ 92201 Retina ☐ 92202 ON/Mac

*Pupil Size After Dilation: OD: _____ mm OS: _____ mm

DIAGNOSTIC IMPRESSION: RECOMMENDATION: ☐ 90Day

☐ Stable (S) ☐ Better (B) ☐ Worse (W) ☐ CPM ☐ Glasses ☐ Med Rx Refills X _____

1. _____ 1. _____

2. _____ 2. _____

3. _____ 3. _____

4. _____ 4. _____

5. _____ 5. _____

6. _____ Over 6. _____ Over

Return To: JIH RMT AGS LSW OD IN: _____ D _____ W _____ M PRN

Next Visit: HVF REF CT SPEC Dilate 2XDP FP OCT-M OCT-O OCT-AS

Sig (OSD/OD/OT) _____ Sig (OD/MD): _____

Doctor: Hoffman Sarraga Taher Williams

MEDICATION PRESCRIPTION

1. For patients on chronic medications (i.e. glaucoma meds)
 - a. write out a prescription at each visit
 - b. circle 3 refills
 - c. check off 90-Day supply
 - d. *if different size bottles are available*, prescribe the correct size for a month supply
 - i. i.e. 1 gtt x BID x OU should be 10 mL
 - ii. i.e. 1 gtt x QD x OU should be 5 mL
2. STEROIDS or STEROID/COMBOs
 - a. NO REFILLS
3. Medication Samples
 - a. samples are kept in NMB Exam Rooms 8,9,10 and FTL Exam Rooms 1,6
 - b. only ONE sample per patient
 - c. document on exam sheet under the assessment that a sample was given by noting an 'S' next to the medication name
4. Medication Coupons
 - a. Medication Coupon box is located by front desk in each office
 - b. Medication coupons can also be found in NMB Exam Rooms 8,9,10 and FTL Exam Rooms 1,6
 - c. document on exam sheet under the recommendation that a sample was given by noting an 'S' next to the medication
5. "PRESCRIBING" ARTIFICIAL TEARS
 - a. When recommending artificial tears, recommend a SPECIFIC brand and give the patient ONE sample or coupon.
 - b. Document on the exam sheet (in the RECOMMENDATION)
 - c. update the MEDICATION RECORD with the *name* of the drop/coupon that was given/recommended. (C with a circle means a coupon was given, S with a circle means a sample was given)
 - d. So that we're all consistent, recommend to use artificial tears **QID OU**.
 - e. Inform the patient that the drops are available over the counter at any drugstore and that there is also a coupon in the box with the sample if a sample was provided
 - f. Have a supply of samples or coupons for artificial tears in your exam room. If you do not have, please ask me or Simone.

MEDICATION PRESCRIPTION

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 - a. write out a prescription at each visit
 - b. circle 3 refills
 - c. check off 90-Day supply
 - d. if different size bottles are available, prescribe the correct size for a month supply
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DAN & HOFFMAN, M.D.'s, P.A. dba EYE CENTERS OF SOUTH FLORIDA

☐ Joseph I. Hoffman, M.D. ☒ Lanelle S. Williams, O.D.

Eye Centers of South Florida - NMB - 2012

☐ Andres G. Sarraga, M.D. ☐ Rashid M. Taher, M.D.

DOE, JANE

☒ 1701 NE 164th Street, 200, NMB, FL 33162; P: 305.947.0027 • F: 305.945.8734

☐ 5333 N. Dixie Hwy., 101, FTL, FL 33334; P: 954.493.5033 • F: 954.493.5058

10/29/1944 CHART # 000000

DATE: 05/27/2020

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Alphagan-P 0.1%
<input type="checkbox"/> Alex 0.2% susp (5) ***
<input type="checkbox"/> Atropine 1% (5,15) **, **
<input type="checkbox"/> AzaSite 1% (2.5)
<input type="checkbox"/> Azopt 1% (15 mL) ***
<input type="checkbox"/> Bacitracin oph ointment **
<input type="checkbox"/> Bepreve 1.5% (10mL)
<input type="checkbox"/> Besivance 0.6% (5 mL)
<input type="checkbox"/> Betimol 0.5% (5,15)
<input type="checkbox"/> Betoptic-S 0.25% ***
<input type="checkbox"/> Betoxolol HCl 0.5%
<input type="checkbox"/> Bimatoprost 0.03% (2.5 mL)
<input type="checkbox"/> Brimonidine Tartrate 0.2%
<input type="checkbox"/> Bromfenac 0.09% (5mL)
<input type="checkbox"/> Combigan (10 mL)
<input type="checkbox"/> Cosopt PF (60 vials)
<input type="checkbox"/> Cyclopentolate 1%
<input type="checkbox"/> Dexamethasone 0.1% | <input type="checkbox"/> Diclofenac 0.1% (Voltaren)
<input type="checkbox"/> Dorzolamide 2% (Trusopt)
<input checked="" type="checkbox"/> Dorzolamide 2%/Timolol .5%
<input type="checkbox"/> Durezol 0.05% (5ml) ***
<input type="checkbox"/> Epinastine (Elestat) 0.05%
<input type="checkbox"/> Erythromycin 0.5% ung **, **
<input type="checkbox"/> Fluorometholone 0.1% **, ***
<input type="checkbox"/> Gatifloxacin 0.5% (5ml)
<input type="checkbox"/> Ilevro 0.3% (3ml)
<input type="checkbox"/> Invelty 1% *** (2.8mL)
<input type="checkbox"/> Ketorolac 0.4% or 0.5%
<input type="checkbox"/> Lacrisert insert (60 inserts)
<input type="checkbox"/> Lastacast 0.25% (3 mL)
<input type="checkbox"/> Latanoprost 0.005% (2.5 ml)
<input type="checkbox"/> Levobunolol 0.5% *
<input type="checkbox"/> Lotemax SM 0.38% (5gm)
<input type="checkbox"/> Lotemax 0.5% **
<input type="checkbox"/> Lumigan 0.01% (2.5mL) | <input type="checkbox"/> NeoPolyDex 0.1% *, **, ***
<input type="checkbox"/> Ofloxacin (Ocuflox) 0.3%
<input type="checkbox"/> Pataday 0.2% (2.5 mL)
<input type="checkbox"/> Patanol 0.1% (5 mL)
<input type="checkbox"/> Pazeo 0.7% (2.5 mL)
<input type="checkbox"/> Pilocarpine _____ % (15ml) *
<input type="checkbox"/> Polysporin eye ointment **
<input type="checkbox"/> Polytrim (10 ml) *
<input type="checkbox"/> Prednisolone Acetate 1% ***
<input type="checkbox"/> Prednisolone Sod Phos 1%
<input type="checkbox"/> Prolensa (0.07%) 1.6, 3ml
<input type="checkbox"/> Restasis 0.05% (60 vials)
<input type="checkbox"/> Rhopressa 0.02% (2.5mL)
<input type="checkbox"/> Rocklatan (2.5mL)
<input type="checkbox"/> Simbrinza (8 ml) ***
<input type="checkbox"/> Timolol 0.50% (5,10 mL) *
<input type="checkbox"/> Timoptic 0.5% Ocudose (60v)
<input type="checkbox"/> Tobradex **, *** | <input type="checkbox"/> Tobramycin 0.3% (5 mL) *
<input type="checkbox"/> Travatan-Z 0.004% (2.5 mL)
<input type="checkbox"/> Travoprost .004% (2.5 mL)
<input type="checkbox"/> Moxifloxacin (Vigamox) (3 mL)
<input type="checkbox"/> Viroptic 1% (7.5 mL)
<input type="checkbox"/> Vyza 0.024% (5 mL)
<input type="checkbox"/> Xiidra 5% (60 vials)
<input type="checkbox"/> Zioptan 0.0015% (30 vials)
<input type="checkbox"/> Zircan 0.15% (5 gm) **
<input type="checkbox"/> Zylet (2.5, 5, 10 mL) ***
ORAL MEDICATIONS
<input type="checkbox"/> Acetazolamide 250 500 mg
<input type="checkbox"/> Acyclovir 200 400 mg *
<input type="checkbox"/> Azithromycin 250mg 5 day
<input type="checkbox"/> Cephalexin 250 500 mg cap
<input type="checkbox"/> Doxycycline 50 100 mg
<input type="checkbox"/> Methazolamide 25 50 mg
<input type="checkbox"/> Valacyclovir 1 gm (tid x 7 d) |
|--|--|--|--|

Drops: ☐ 2.5mL ☐ 3mL ☐ 5mL ☐ 5.5mL ☐ 8mL ☒ 10mL ☐ 15mL ☐ _____ mL Vials: ☐ 30 ☐ 60 Ointment **: ☐ 3.5gm Oral: # _____

Instill 1 gtt: ☐ OD ☐ OS ☒ OU or Apply ½ inch to ☐ _____ R ☐ _____ L Lids or Take by mouth: _____ tab / cap

☐ As Directed (e.m.p.) ☐ QD ☐ QAM ☒ BID ☐ TID ☐ QID ☐ QHS ☐ Q _____ H ☐ PRN; Duration X _____

☒ Refill: 0 1 ☒ 3 6 12 PRN ☒ 90-Day Supply ☐ Brand Medically Necessary ☐ Shake well ***

☐ Dispense one Rx based on lowest cost or formulary coverage (MultiMedRx rev. 53 5.13.19) Dr. _____

1- When recommending artificial tears, recommend a **SPECIFIC** brand and give the patient **ONE** sample or coupon.

2 - Document on the exam sheet (in the **RECOMMENDATION**) and update the **MEDICATION RECORD** with the ***name*** of the drop/coupon that was given/recommended. (**C** with a circle means a coupon was given, **S** with a circle means a sample was given)

3- So that we're all consistent, recommend to use artificial tears **QID OU**.

4- Inform the patient that the drops are available over the counter at any drugstore and that there is also a coupon in the box with the sample if a sample was provided.

5- Always have a supply of samples or coupons for artificial tears in your exam room. If you do not have, please ask me or Simone.

**Dr. Hoffman's favorite artificial tear is the one that he has a sample!*

GLASSES PRESCRIPTION

Anytime a patient has a manifest refraction, a complete prescription (distance and near add) should be written out and attached to the front of the chart for the doctor to sign. SEE BELOW FOR DETAILS ON WRITING A GLASSES PRESCRIPTION

1. You may use a preprinted patient label, located on Side A of the chart.
2. Check the name of the doctor who will be signing the prescription.
3. Write the date the refraction was done. (This may not be the same as the date that the prescription is given, for patients who simply request a copy of their last prescription.)
4. Distance prescription with near add. You may use age-tables or trial frame to determine the patient's add.
5. Check the recommended type of glasses.
6. Check any recommended material/treatment.
 - a. POLYCARBONATE FOR MONOCULAR PATIENTS AND CHILDREN!
 - b. Consider SLAB-OFF if prescribing Bifocals or Progressives on anisometropic presbyopes who has a difference in the vertical meridian of more than 1.50. (To determine the exact amount of vertical deviation, you may use this website {should be bookmarked on computers in exam rooms}
<http://www.robertsonoptical.com/Slab-OffCalculator.aspx>)
7. For post-op patients, indicate the date(s) of the surgery.
8. Name of individual who wrote the prescription.

Sample Prescription Distance/Near BF or Progressive Prescriptions

DAN & HOFFMAN, M.D.'S, P.A. dba EYE CENTERS OF SOUTH FLORIDA

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Eye Centers of South Florida - NMB - 2012

☒ Lanelle S. Williams, O.D.

www.myeeyecenters.com

1701 NE 164th Street, #200, North Miami Beach, FL 33162

Phone: 305.947.0027 • Fax: 305.945.8734

DATE: 05-07-14

DOE, JANE

10/29/1944 CHART # 000000

EYE	SPHERE	CYLINDER	AXIS	ADD	PRISM	BASE
OD	+1.00			+2.50		
OS	+1.00			+2.50		

TYPE : ☐ DISTANCE ☐ READING ☐ COMPUTER ☒ PROGRESSIVES ☐ BIFOCAL ☐ TRIFOCAL ☐ COMPUTER BF / PAL

MATERIAL/TREATMENT: ☒ AR COATING ☐ POLYCARBONATE ☐ SCRATCH RESISTANT ☐ SLAB-OFF ☐ U.V. FILTER

P.O. PSEUDOPHAKIC: ☐ OD Date of Surgery: _____ ☐ OS Date of Surgery: _____

COMMENTS : _____

ECOSF Eyeglass Prescription NMB 2014

OD/OS Matt

Signature: _____

RESTASIS STARTING INSTRUCTIONS

Extern Name: _____ Date: _____

Please go over the Information and Instructions below with Patient:

Patient Information:

- ☐ Restasis works by helping your tear gland produce more tears, improve the quality of your tears and reduce the ocular inflammation
- ☐ Restasis is a medication, NOT an artificial tear
- ☐ Restasis drops may cause some burning initially. This is normal and lessens with time.
 - ☐ Even less burning is experienced with the MultiDose bottle (same cost as the vials)
- ☐ It may take approximately 4 weeks before you start producing more tears and experience an improvement in your symptoms

Patient Instructions:

- ☐ Continue using Artificial Tears while on Restasis.
- ☐ Your use of artificial tears may decrease as you begin to produce more of your tears
- ☐ Restasis comes in a tray that contains 30 vials or in a MultiDose 5.5mL bottle
- ☐ Use 1 drop of Restasis in each eye twice a day
- ☐ **Vials:** Start the vial in the evening, use the second dose (same vial) in the morning and then discard the vial
- ☐ **Bottle:** Prime the bottle by squeezing out two drops onto a tissue before using. Turn the bottle upside down a few times before using to mix the medicine well.

Give the following to Patient:

- ☐ **Prescription for Restasis:**
 - 1month supply (2 trays/60 vials OR 5.5mL), 1 drop OU BID (12 Refills)
 - ☐ If patient has mail order plan, then circle 3 refills and 90-Day Supply
- ☐ Does your patient have Medicare, Medicare HMO or Medicaid? ☐ YES ☐ NO
- ☐ **If NO, then give Restasis brochure/leaflet (in assisting rooms and chart pick up area)**
 - ☐ Tell patient to follow the instructions on the brochure/leaflet to get their digital savings card by texting or going online, most commercially insured patients will pay no more than \$30 for one bottle or \$5 for 3 bottles
- ☐ **If YES, savings card does not apply. Medicare should cover Restasis for a low copay.**

Special:

- ☐ Contact Lens Wearers: advise patient to wait 15 minutes before inserting CL
- ☐ Symptomatic: Give a prescription of Alrex, FML or Lotemax to use BID-QID X 4weeks (0 refills)

FAQ's:

1. How long will I have to take Restasis? Until we find a better treatment or a cure
2. How long will it take to feel the improvement? It could take 3 months to 6 months after beginning therapy to notice an increase in tear production. Benefits will continue with continued use of Restasis.
3. Are there other drops out there like Restasis? Xiidra is another medicated drop, and an alternative to treating dry eye.

EYE CENTERS OF SOUTH FLORIDA (D) W2HP

NAME: _____

RESTASIS STARTING INSTRUCTIONS (06/14/18)

DOB: _____ CHART#: _____

XIIDRA EXTERN STARTING INSTRUCTIONS CHECKLIST

Extern Name: _____ Date: _____

Please go over these instructions and information with the Patient:

Important Information re: XIIDRA 5%

- Xiidra is a prescription eye drop used to treat the signs and symptoms of dry eye disease.
- Xiidra is NOT an artificial tear.
- Artificial tears can and should be continued.
- Most common side effects include: eye irritation, blurry vision for up to 20 minutes and an unusual taste sensation.

Instructions for use:

- Use Xiidra twice per day, about 12 hours apart.
- Xiidra comes in single dose plastic containers that are NOT recappable.
- You will be using 2 containers per day.
- Do not let the tip of the vials touch your eye or any other surfaces.
- Contact Lens Wearers: Remove contact lenses before using the drops.
- Wait 15 minutes before inserting contact lenses.

Xiidra insider Savings:

- **Medicare and Medicaid patients**: Advise patient to call the number inside the white Xiidra brochure to check coverage.
- **Commercial Insurance patients**: With savings card (inside yellow Xiidra brochure), may pay as little as \$5.
- **Cash-pay patients**: Advise patient to call the number inside the white Xiidra brochure to check coverage.

Give the following to Patient:

- Yellow Xiidra brochure with savings card.
- If available, give the patient a sample box of Xiidra (20 vials lasting 10 days)
- Did you give the patient the "Dry Eye Relief" brochure? Yes ____ No ____
- **Rx**: 1 month supply (60 vials), 1 drop OU BID, 12 refills.
- If patient has mail order plan, then circle 3 refills and 90-Day Supply.

FAQ's:

- Q. How long will I have to use Xiidra? Until we find a better treatment or a cure.
- Q. How long will it take to notice improvement? As little as 2 weeks, but it can take up to 12 weeks of continuous use.
- Q. Should I continue with the Warm Compresses/ Fish oil/ Artificial Tears? Yes!

Created by Emir Hadzic (09/22/16) Revision by Brij Patel (07/02/17)

EYE CENTERS OF SOUTH FLORIDA (D)

NAME: _____

XIIDRA STARTING INSTRUCTIONS (03/07/19)

DOB: _____ CHART # _____

OPHTHALMOLOGY EXAM REPORTS

Ophthalmology Exam Reports are used to communicate exam findings to the referring physician and other physicians in the care of the patient.

- These reports should be completed by the extern who sees the patient, but can be completed by anyone available.
- They should be completed by the end of each day.
- See sample Ophthalmology Exam Report for instructions on how to fill in the blanks.

NPI NUMBERS

A quick and easy way to find a doctor's contact information (address, phone number, and usually fax number) is by searching their National Provider Identifier (or NPI). You can use either of these websites: <http://www.npinumberlookup.org> or <https://npiregistry.cms.hhs.gov> and enter the doctor's first and last name and state in the search bar.

A **National Provider Identifier** or **NPI** is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI is used by other payers, including commercial healthcare insurers. <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/>

SAMPLE



Fax numbers can be found:

- ECCEF phone/fax directory binder in file room
- www.npinumberlookup.org
- Google and call office for fax number

Dan & Hoffman, M.D.'s, P.A.
EYE CENTERS OF SOUTH FLORIDA

Write First AND LAST
Name of Doctors

OPHTHALMOLOGY EXAMINATION REPORT

Patient Name: DOE, Jane Date Seen: 04/21/15
(Last, First)

Primary Care Physician: Dr. Roza Gurarye FAX #: (305) 948-8248

Optometric Physician: Dr. Alan Grossman FAX #: (305) 466-0773

Specialist / Other: _____ FAX #: _____

Dear Doctor(s): Ex) Endocrinologist [DO NOT send to previous ophthalmologist]

We recently had the pleasure of seeing the above named patient for an ophthalmic examination. The following is a summary of the significant observations, findings, treatments and/or recommendations:

Vision: sc (cc) OD: 20/20 OS: 20/30 IOP: OD: 18 mm Hg OS: 18 mm Hg

Impression and/or Diagnostic Findings: circle one write actual tonometry measurement, NOT the adjusted reading

- Cataracts, both eyes
 - glaucoma suspect, both eyes
 - _____
- DO NOT use abbreviations
Ex: "right eye" instead of "OD"

Plan, Treatment and/or Recommendations:

- Schedule cataract surgery, left eye and then right eye
 - Monitor intraocular pressure and visual field in 3 months
 - _____
- DO NOT use abbreviations

If you have any questions or need any additional information, please do not hesitate to contact our office.

Best Personal Regards,

* Name of person who completed the form
Report Completed by: Bonnie

Sig: _____

Problem List Sheet Updated: ☒ YES

Ophthalmology Examination Report (11/16)

* DO NOT forget to update problem list in chart
Lewis R. Dan, M.D. • Joseph I. Hoffman, M.D.

Andres G. Sarraga, M.D. • Rashid M. Taher, M.D. • Lanelle S. Williams, O.D.
1701 N.E. 164th Street • 2nd Floor • N. Miami Beach, FL 33162-4018 • 305-947-0027 • Fax 305-945-8734
5333 North Dixie Highway • #101 • Fort Lauderdale, FL 33334-3453 • 954-493-5033 • Fax 954-493-5058
Email: info@myeyecenters.com - Internet: www.myeyecenters.com

* once completed, place in doctor's inbox to be signed

PROTOCOLS FOR SPECIALISTS

OCULOPLASTIC WORK-UP FOR DR. SARRAGA

NEW/ESTABLISHED PATIENT

HISTORY- patient's age, race and sex, chief complaint (in patient's own words), history of present illness (duration, aggravating factors, treatment to date, history of similar problem in past), past medical history (ask specifically about heart disease, lung disease, kidney disease, diabetes, high blood pressure, stroke, seizures or cancer), current medications (ask about aspirin or blood thinners)

VA (cc)- distance only best corrected visual acuity

WHENEVER YOU ARE NOT WITH A PATIENT, YOU SHOULD SHADOW DR. SARRAGA

RETINAL CONSULT WORK-UP FOR RETINAL SPECIALIST

NEW PATIENT

History
VA (cc)- distance, near
Pupils/Motility/Confrontation Fields
Intraocular Pressures
Dilate (M & N)

ESTABLISHED PATIENT

History
VA (cc)- distance
Intraocular Pressures
Dilate (M & N)

WHENEVER YOU ARE NOT WITH A PATIENT, YOU SHOULD SHADOW DR. TAHER

SPECIALIST/SURGERY OBSERVATION PROTOCOL

OBSERVING SPECIALISTS IN AN AFFILIATED OFFICE

- Refer to the ECOSF Affiliated Offices Locations/Addresses sheet (located in section 1 of the orientation packet, in the Dropbox and also posted near the chart pick up area in both offices) for information about the office (including address, phone number and any special instructions)
- Read prior reviews for additional information and expectations from the experience.
- Call the office a minimum of 2 days in advance to confirm that the doctor will be in and the time to arrive.
- Plan to arrive at the office a little early.
- BE ATTENTIVE AND ACT INTERESTED!
- Send Dr. Williams a feedback email within 24 hours of the completion of the day consisting of:
 1. number of patients seen
 2. 2 to 3 things that you learned from the experience
 3. rate your experience, 1 to 5 (5 being "please please schedule me again tomorrow")
 4. what type of EMR do they have? what do you think of it?
 5. any recommendation for future externs (i.e. where to park, bring a snack, etc..)
 6. any additional comments

OBSERVING SURGERY ***SUSPENDED DUE TO COVID-19***

- Refer to the ECOSF Affiliated Offices Locations/Addresses sheet (located in section 1 of orientation packet, in the Dropbox and also posted near the chart pick up area in both offices) for information about the office (including address, phone number and any special instructions)
- Read prior reviews for additional information and expectations from the experience.
- Ask Simone a minimum of 2 days in advance to confirm the doctor will be operating and the time to arrive.
- Email the doctor the day before to inform him that you will be observing him in surgery and the time you will be arriving. (Dr. Hoffman- eyemd81@gmail.com, Dr. Taher- rmtaher@hotmail.com, Dr. Sarraga- andressarraga@yahoo.com, Dr. Kubal- aarup.kubal@gmail.com)
- Plan to arrive at the facility at least 20 minutes before the first case.
- ***DO NOT WEAR PERFUME/COLOGNE***
- In the Operating Room:
 1. No cell phones
 2. The circulating nurse may have to get to something for the surgeon quickly--
externs should not move so she can easily walk around
 3. If the circulating nurse asks you to move to a certain area--do it promptly
- BE ATTENTIVE AND ACT INTERESTED!
- Send Dr. Williams a feedback email within 24 hours of the completion of the day consisting of:
 1. number of patients seen
 2. 2 to 3 things that you learned from the experience
 3. rate your experience, 1 to 5 (5 being "please please schedule me again tomorrow")
 4. any recommendation for future externs (i.e. where to park, bring a snack, etc..)
 5. any additional comments

ECOSF AFFILIATED OFFICES LOCATIONS/ADDRESSES

EYE CENTERS OF SOUTH FLORIDA

NORTH MIAMI BEACH OFFICE (NMB)

1701 NE 164TH STREET, SUITE 200
N. MIAMI BEACH, FL 33162
305-947-0027

FORT LAUDERDALE OFFICE (FTL)

5333 N. DIXIE HWY, SUITE 101
FT. LAUDERDALE, FL 33334
954-493-5033

NORTH MIAMI BEACH SURGICAL CENTER (NMBSC)

120 NE 167th STREET
N. MIAMI BEACH, FL 33162
305-940-5100 ***DO NOT WEAR PERFUME/COLOGNE**
**email doctors the day before to inform them that you are shadowing and the time you were told to arrive- eyemd81@gmail.com, aarup.kubal@gmail.com, rmtaher@hotmail.com, andressarraga@yahoo.com*

PHYSICIANS OUTPATIENT SURGERY CENTER (POSC)

1000 NE 56TH STREET
FORT LAUDERDALE, FL 33334
(954) 229-6090 ***DO NOT WEAR PERFUME/COLOGNE**
****bring a copy valid photo ID & completed Clinical Observation Form****
**email Dr. Hoffman the day before to inform him that you are shadowing and the time you were told to arrive- eyemd81@gmail.com*

DR. KENNETH MALLER@ ECOSF FORT LAUDERDALE OFFICE (FTL) (see above)

**ask our front desk staff for starting time
will take a picture & post on social media

DR. MATTHEW KAY @ ELGUT EYE CARE (EEG) MEDICAL ART PAVILLION

6333 N. FEDERAL HIGHWAY, SUITE 401
FORT LAUDERDALE, FL 33308
954-463-4761

DR. GABRIEL LAZCANO/ DR. ABRAHAM AWAD @ LASER EYE CENTER OF MIAMI

1661 SW 37 AVENUE
MIAMI, FL 33145
305-443-4733 (call Diana)
**may take a picture & post on social media
*DO NOT WEAR PERFUME/COLOGNE
(8:00am to ~5:00pm), lunch room available to eat lunch*

DR. RASHID TAHER @ RETINA ASSOCIATES NMB OFFICE

184 NE 168 STREET
N. MIAMI BEACH, FL 33179
305-655-0411

CORAL GABLES OFFICE (San Rimo Plaza?)

6705 RED ROAD, SUITE 514
CORAL GABLES, FL 33143
305-666-8850

(start at 8:00am on Thurs. & 1:00pm on Fridays)

NORTH MIAMI BEACH SURGICAL CENTER (NMBSC)

120 NE 167th STREET
N. MIAMI BEACH, FL 33162
305-940-5100 ***DO NOT WEAR PERFUME/COLOGNE**
**email Dr. Taher the day before to inform him that you are shadowing and the time you were told to arrive- rmtaher@hotmail.com*

MARCIA CIEPIELEWSKI (OCULARISTS) @ PROSTHETIC EYE INSTITUTE (PEI)/SNG LABS DELRAY BEACH OFFICE

16244 SOUTH MILITARY TRAIL, SUITE 420
DELRAY BEACH, FL 33484

WEST PALM BEACH OFFICE

2000 PALM BEACH LAKES BLVD., SUITE 400
WEST PALM BEACH, FL 33409 (in the BB&T building)
561-391-7099 (call Julie for both locations)
ALSO AT ECOSF NMB & FTL OFFICES

DR. WILLIAM TRATTLER @ CENTER FOR EXCELLENCE IN EYE CARE (CEEC)

BAPTIST MEDICAL ARTS BUILDING
8940 N. KENDALL DRIVE, SUITE 400-E
MIAMI, FL 33176

*(305) 598-2020 *wear professional attire w/coat
(9:30am to 5:30pm), can eat in or go out for lunch*

DR. ELISE KRAMER

@ MIAMI CONTACT LENS INSTITUTE

2627 NE 203RD ST., SUITE 116
Miami, FL 33180, 305-814-2299
(Mon 9:00 - 5:00, Fri 10:30 - 5:00)

**use the complimentary valet for your car at Miami*

@ WESTON CONTACT LENS INSTITUTE

2863 Executive Park Dr. #103
Weston, FL 33331, (954) 217-2992
(Tues, Wed & Thu- 10:00 to 5:00)

**review the basics of keratoconus*

EXTERN LUNCH PROTOCOL

When working with the general ophthalmologists at the NMB and FTL offices, lunch is usually provided by ECOSF. It is very important that the process is smooth and efficient or else it can negatively impact the educational objectives for lunchtime activities and the afternoon patient schedule. In addition, it is important to understand that there is a limited budget for lunch, so please try to be judicious in your lunch choices (*no meals over \$10*). Lunch being provided by ECOSF is a privilege, and we want to continue with this lunch program.

NMB OFFICE

1. *The afternoon assistant should choose a place and start a list for the next lunch session.*
2. The morning assistant will:
 - confirm (or choose) a place (if it already has not been decided)
 - review (or start) the list (if it has not already been started)
 - get a volunteer to place the order
 - get a volunteer to pick up the order
3. The extern ordering **MUST** place the order by **11:00 am**, for a **12:00 pm** pick up. If this person is unable to order, please find someone available at 11:00 to order.
4. The extern picking up **MUST** leave by **11:45 am** to pick up the order. **DO NOT FORGET TO TAKE THE CREDIT CARD** (located in the blue cabinet, top drawer in the ophthalmologists' office).
5. There are bottles of water and sodas in the refrigerator, so please do not order any drinks.
6. *Anything else desired, can be paid for separately.*

FTL OFFICE

1. Externs will go to lunch at the Holy Cross Healthplex Women's Center Cafe (5 minute walking distance from the office).
2. Since there is usually a large group, starting at 12:00pm, whoever is finished with patients should start going to lunch.
3. The first person going should get the credit card from Dr. Hoffman.
4. Please limit your order to 1 meal and a drink.
5. *Anything else desired, can be paid for separately.*

ECOSF EXTERN CLINICAL PROTOCOL CHECKLIST- VISITS

☐ 1 DAY POST-OP CATARACT

- Remove eye shield and eye bandage, clean lids and lashes if needed.
- Distance uncorrected and pinhole VA of operated eye.
- Anterior segment evaluation of both eyes (evaluate status of other eye cataract if present)
- Tonometry of operated eye. ***do not use Fluress, use proparacaine and fluorescein strips**
- Review PO gtt's and review and GIVE patient PO Instruction Sheet.
- **Complete PO Assessment & Plan on progress note (see samples posted & in Exam rooms).**

POST-OP: After surgery, patients start the antibiotic (ofloxacin or gatifloxacin or polytrim) QID for 1 week and NSAID (diclofenac or ketorolac) QID for 2 weeks and start prednisolone QID x 4 weeks, then BID x 2 weeks (**see Post-Op Instruction sheet**). **Prescription for all 3 drops are given at surgery scheduling visit.**

☐ 1 WEEK POST-OP CATARACT

- Distance, pinhole and near uncorrected VA of operated eye. Auto-refractor of operated eye.
- Tonometry of operated eye(s) & anterior segment evaluation of both eyes (evaluate status of other eye cataract?)
- **Dilate** if patient meets any of the following criteria: unable to view the posterior pole pre-operatively due to mature cataract, signs & symptoms of retinal detachment, pain or suspected endophthalmitis, unexpected level of inflammation for post-operative period, unexplained decrease in best corrected visual acuity, intra-surgical complications (posterior capsule rupture or retained lens particles).
- Complete PO Assessment & Plan on progress note (see samples posted).
- ****If other eye was operated within 1 month, perform tests on both eyes****

☐ 4 WEEK POST-OP CATARACT

- Distance, pinhole and near uncorrected VA of operated eye(s).
- Auto-refract OD, OS.
- Refraction OD, OS. Write the prescription, including date of surgery. (Even if Optometry referred, REFRACT, because if patient presents for 4 week post-op visit, then they are not being co-managed.)
- Anterior segment evaluation of both eyes (evaluate status of other eye cataract if present) & Tonometry of operated eye(s)
- Dilate if patient meets any of the criteria listed above for 1 week post-op.
- Complete PO Assessment & Plan on progress note (see samples posted).

☐ 4 MONTH POST-OP CATARACT

- Distance and near corrected VA OD, OS (with new glasses).
- Auto-refractor OD, OS.
- Lensometry- new glasses.
- Refraction OD, OS if VA changes and if NOT Optometry referred.
- Anterior segment evaluation & Tonometry and OD, OS.
- **NMB office only**-Specular microscopy OD, OS.
- Dilate operated eye if patient has not been dilated s/p operation.
- Complete PO Assessment & Plan on chart.
- Remove post-op flags from bottom of chart and place on Outpatient Procedure Form

PRE-OP VISIT

- Write operative eye and date of surgery.
- REVIEW Cataract Surgery Pre-Op Medication Questionnaire and Cataract Surgery Lifestyle Questionnaire and place under current exam sheet.
- Distance corrected VA OD, OS
- Anterior segment evaluation OD, OS.
- Tonometry OD, OS.
- Dilate operative eye if it has not been done within 4 weeks.
- Record dilated pupil size.
- Perform a macula OCT if it has not been done within 3 mos.

☐ 1 WEEK POST-OP YAG CAPSULOTOMY

- Check distance VA OD, OS.
- Auto-refractor and refraction if needed OD, OS.
- Anterior segment evaluation.
- Tonometry post-op eye.
- Dilate post-op eye.
- (schedule next visit for 4 months)

☐ 1 WEEK POST-OP LASER PERIPHERAL IRIDOTOMY

- Check distance VA OD, OS.
- Anterior segment evaluation. Confirm open iridotomy.
- Tonometry OD, OS.
- **Gonioscopy.**
- **Anterior Segment OCT of angles.**
- Check if other eye is scheduled to be treated (Advise a Tech).
- **If both eyes had LPI and angles are open (based on gonio and OCT), dilate OU.**

☐ 1 WEEK POST-OP ARGON LASER TRABECULOPLASTY

- Check distance VA OD, OS.
- Tonometry OD, OS.
- Anterior segment evaluation.

☐ 2-4 WEEK FOLLOW-UP ACUTE PVD

- Check distance VA OD, OS.
- Tonometry OD, OS.
- Anterior segment evaluation.
- DILATE AFFECTED EYE (phenyl & tropicamide)

☐ 3-6 MONTH GLAUCOMA CHECK

- Check distance VA OU.
- Anterior segment evaluation OU.
- Tonometry OU.
- Dilate OU if last dilation was more than 6 months.
- Optic Nerve OCT OU (once a year)
- Fundus/Optic Disc photos OU (once every 2 years)
- *Do not perform Optic Nerve OCT and Fundus Photos on the same visit**

☐ NEW NARROW ANGLE PATIENT

- Follow New Patient Protocol UP TO IOP/SLIT LAMP
- Perform 4-mirror gonioscopy OU (92020)
- Anterior segment OCT of angles OU. (92132)
- See Anterior Segment OCT Protocol posted
- **DO NOT DILATE!**

☐ RED EYE VISIT

- See RED EYE CHECKLIST (SMART FORMS)

☐ GLASSES CHECK

- See NEW GLASSES COMPLAINT ASSESSMENT CHECKLIST

☐ CONTACT LENS VISITS

- See Dr. Williams

CATARACT WORK-UP, MINOR SURGERY or LASER VISIT

- Chart goes directly to Simone or Nancy

ECOSF EXTERN CLINICAL PROTOCOL CHECKLIST- TESTS

OPTICAL COHERENCE TOMOGRAPHY

- An Optic Nerve OCT (92133) should be performed on:
 - New Patients: glaucoma/suspect/narrow angles
 - Established patients: glaucoma/suspect/narrow angles/ every 12 months.
- A Macula OCT (92134) should be performed on:
 - New Patients: AMD, Diabetes, maculopathy, retinopathy
 - Established patients: AMD, Diabetes, maculopathy, retinopathy maculopathy patients every 12 months.
 - patients who recently had intravitreal injections for macular pathology.
- The date the test was performed should be logged on the OCT divider in the Specialty Testing/Surgery Section in the chart (side B).
- Enter spherical equivalent for patients with high refractive errors & enter in comment section of OCT Log Form
- Circle the superbill- CPT codes 92132 Ant Seg, 92133 Optic Nerve, 92134 Retina
- *On established patients, do not perform Optic Nerve OCT and Fundus Photos on the same visit*

VISUCAM DIGITAL FUNDUS PHOTOGRAPHY

- Fundus and Disc photos and (montage photos for diabetics) should be performed on:
 - new patients who are dilated.
 - established patients every 12 months.
- The date the photos were taken should be logged on the Visucam Digital Photography log in the Specialty Testing/Surgery Section in the chart (side B).
- Circle the superbill- CPT code 92133.
- Patients with Pterygia should have anterior segment photos using the Visucam, Circle CPT 92285.
- *On established patients, do not perform Optic Nerve OCT and Fundus Photos on the same visit*

ANTERIOR SEGMENT PHOTOGRAPHY

- An anterior segment photo (either with anterior segment camera (in NMB), digital camera, or smart phone) should be performed on:
 - new patients/established patients with any suspicious/significant/unusual anterior segment findings (i.e. eyelid/conj/corneal lesions, corneal ulcers...)
- See anterior segment photography instruction sheet.

CORNEAL TOPOGRAPHY

- Corneal topography should be performed on:
 - new patients with keratoconus, high astigmatism, large pterygia, refractive surgery candidates or s/p refractive surgery.
 - established patients with keratoconus every 12 months, patients with a large change in astigmatism, refractive surgery candidates, cataract surgery candidates
- The test results are placed in the Specialty Testing/Surgery Section in the chart (side B).
- Circle the superbill- CPT code 92025..

GONIOSCOPY

- Gonioscopy should be performed once per year on: glaucoma patients, glaucoma suspect, narrow angles, high IOP's, patients with Kruckenberg spindles, prescription > + 3.00 D, post LPI, h/o blunt trauma.
- ONLY USE A 4-Mirror Gonio lens WITHOUT a flange.
- Record findings on the examination sheet.
- Circle the superbill- CPT code 92020
- NEVER PERFORM GONIOSCOPY ON POST-OP PATIENTS.**

PACHYMETRY

- Pachymetry should be performed on:
 - new patients
 - established patients without previously recorded pachymetry measurements or with only 1 pachymetry measurement performed more than a year before
 - patient's with Fuch's Dystrophy
- Record on exam form and Pachymetry Record Form (side C).
- Circle the superbill- CPT code 76514

AUTO-REFRACTOR

- Auto-refractor should be performed on: all new patients (except red eyes), established patients every year, post-ops (as indicated on post-op protocols), glasses checks.
- Record results, including best vision on exam notes, and tape printout to back of exam notes.

AUTO-LENSOMETRY/LENSOMETRY

- Auto-lensometry should be performed on: all new patients (except red eyes), whenever a refraction is performed, glasses checks

- Record results, type of glasses (BF, PAL, NVO...), color/style of frame (if multiple glasses), age of glasses, and tape printout to back of exam notes

REFRACTION POLICY (also SEE REFRACTION FAQs)

- Refractions should be performed on (non-optometry referred):
 - NEW patients- ask the patient, inquire for blurry VA or want new to leave with a new glasses prescription
 - ESTABLISHED patients- ask the patient if last refraction was more than 1 year
 - complaints with current RX or decrease in VA
 - if considering cataract surgery, perform a QUICK diagnostic refraction
- After performing a refraction:**
 - ALWAYS record on current exam notes as complete distance refraction including distance VA, near add and near VA.
 - ALWAYS circle the superbill- 'REFRACTION 92015'
 - ALWAYS write out a prescription and attach it to the front of the chart.
- Refraction Notice:**
 - The refraction Notice is given to all patients (at least once) to inform them of the \$50 fee for refraction.
- If a patient declines a refraction, document on exam notes.

VISUAL FIELD POLICY

FREQUENCY DOUBLING TECHNOLOGY (FDT) SCREENING VF:

- A screening visual field (N-30-5) should be performed on:
 1. new patients, even if they had a previous diagnosis of glaucoma
 2. established patients who have not had a HVF within a year
- The FDT field will be performed by the Optometry Extern or Ophthalmic Technician working up the patient.
- The test results strips will be taped to the "FDT VISUAL FIELD" FORM and placed in the Visual Field Section of the chart (side C).
- Circle the superbill; the CPT code for this test is 92081 (Visual Field Screening).
- FDT CAN be done while patients are dilating.

THRESHOLD HUMPHREY VISUAL FIELDS:

- A Humphrey visual field 24-2 SITA FAST (unless indicated otherwise) should be performed on:
 1. Established Glaucoma or Glaucoma Suspects who have not had a Humphrey visual field.
 2. Established Glaucoma or Glaucoma Suspects every 6mths.
 3. A previous FDT defect.
- The Humphrey visual field will be performed by the Extern or Ophthalmic Technician assigned.
- A VISUAL FIELD REQUEST FORM should be completed by whoever works up the patient.**
- Circle the superbill; the CPT code for this test is 92083 (Visual Field Extended).
- Patients should not have a visual field performed while they are dilating, either before or after.
- If a patient refuses a visual field test, simply explain the purpose of the test. If the patient still refuses, then note it on the chart.

DILATION POLICY (also SEE DILATION FAQs)

- New patients should be dilated.
 - EXCEPTIONS: occludable angles, infections, IOP's > 30,
- Established patients should be dilated every 12 months.
- Established patients with retinal conditions should be dilated every six months, e.g. ARMD, diabetics, glaucoma, HIV+, patients on plaquenil, ethambutol...
- Patients who present with a problem that may indicate a new retinal condition, e.g. flashes/floaters, trauma, a new positive amsler defect, sudden decrease in vision,...
- Patients should be dilated with tropicamide or Paremyd; if a patient dilates poorly or has possible peripheral retinal pathology or is scheduled with Dr. Taher, then dilate with both tropicamide and phenylephrine. RECORD POST DILATION PUPIL SIZE.
- If patient is diabetic, complete the Diabetic Retinopathy-Medicare PQRS form (located in the smart forms box and with the patient education forms in the exam rooms).

SCHIRMER TEAR TEST

- Perform on new or established patients with dry eye symptoms
- Usually 1 Schirmer Tear Test is sufficient (i.e. does not need to be repeated).
- See Schirmer Tear Test Recording Sheet (in exam rooms) for instructions and to record results. Place form in side D of the chart.

***Check each time (up to 3x) when each of these tests are performed. Return this sheet to Dr. Williams after 3 weeks into the rotation.**

RED EYE PPP CHECKLIST – NMB OFFICE

OD/OS/OT Name: _____ Date: _____

Chief Complaint or Nature of Visit of “Red Eye” (Code Red)

- ☐ Bring patient directly to ROOM 10 if available. If there is an assistant assigned to room 10, hand off patient to assistant to workup. If Room 10 is not available, examine patient in your exam room (and keep patient in that room).
- ☐ Ask patient to place patient's personal belongings on the visitor chair (purse/keys/etc.)
- ☐ Explain to patient that they may have an infection or “Pink Eye” which might be contagious
- ☐ While patient is standing, apply a few pumps of anti-bacterial hand sanitizer onto the patient's hands and on your own hands
- ☐ Have the patient sit in exam chair
- ☐ Put gloves on (box of gloves should be located in top drawer or cabinet of exam room).
- ☐ Take a detailed problem focused history.
- ☐ If the patient is a contact lens wearer, complete a **“contact lens history form.”**
- ☐ Take distance vision with you holding the single handle occluder or with tissue under their glasses (wipe occluder with chlorox/disinfectant wipe immediately after).
- ☐ Have patient place their glasses in their shirt pocket or on top of tissue or paper towel.
- ☐ Perform external examination and pay attention to eyelids and conjunctival injection.
- ☐ Using Q-tips, gently pull down lids and look at pattern of injection and look for palpebral conjunctival follicles, mucus, discharge, etc.
- ☐ Place a tissue on the chin rest of the slit lamp prior to examining the patient.
- ☐ Examine patient at Slit lamp – check conj and cornea carefully.
- ☐ If Herpes is suspected, check corneal sensation prior to instilling any drops.
- ☐ If tonometry planned, make sure not to contaminate anesthetic eye drops.
- ☐ **Do not perform Goldmann applanation tonometry.** Use Tonopen.
- ☐ *If AdenoPlus RPS is indicated, discuss with patient and consult the doctor before performing (see AdenoPlus Conjunctivitis Testing Sheet).*
- ☐ Remove gloves to avoid contamination onto patient chart and writing instrument
- ☐ Write down your findings, Impression and Plan (even if you're not sure).
- ☐ Begin filling out prescription with patient's name and date.
- ☐ Have 4 exam gloves and cotton swabs set aside on top of the open chart for the Doctor's use.
- ☐ If in Room 10, prepare computer for external slit lamp photos, take photos if indicated and leave slit lamp on.
- ☐ **Assistant:** While the doctor is examining and talking to the patient, please SCRIBE additional history and exam findings.
- ☐ Complete filling out prescription and give patient appropriate Patient Instructions (**Viral Conjunctivitis Patient Education Form**) and/or other forms as instructed by the doctor.
- ☐ Walk the patient out to check out area, and GIVE CHART to front desk check out
- ☐ Inform check out and check in receptionist if patient has contagious “pink eye” and Instruct them to use contagious precautions on themselves (Purell) and for other patients (i.e. careful to wipe pens, etc.)
- ☐ Return to Exam Room 10 or your exam room, put on gloves and using disinfecting wipes, sanitize the entire exam room areas and anything that the patient may have touched.

(Clinical Protocol started by Nadia and modified by Amy Abraham and Dr. Hoffman, updated by Wes and Jackie Gloves)

EYE CENTERS OF SOUTH FLORIDA

NAME: _____

RED EYE CHECKLIST NMB (rev. 06/21/2016) (D) W/2HP

DOB: _____ CHART#: _____

**ECOSF EXTERNAL PHOTOGRAPHY PROTOCOL
for IPHONE/SMARTPHONE:**

External Eye Photography is photography of the external structures of the eye and surrounding anatomy without the aid of a microscope. It is performed mostly for documentation and/or to follow the regression or progression of disease. This is different to anterior segment photography.

External Photography should be performed using the external photography smartphone (located at the front desk check-in area in each office), on anything abnormal externally (*i.e. ptosis, dermatochalasis, chalazion, eyelid lumps and bumps, rash, dermatitis, shingles, trauma, infections...*)

STANDARD EXTERNAL PHOTOGRAPHY (For eyelids and external pathology)

Please see sample pictures in all exam rooms.

1. Take one picture of the patient's information (name, age, gender, etc) located on the super bill (horizontally)
2. Take two pictures of the RIGHT eye (close-up, horizontally)
3. Take two pictures of the LEFT eye (close-up, horizontally)
4. Take two pictures of the BOTH eyes (close-up, horizontally)
5. Take one picture of the entire face NORMAL (close-up, vertically)
6. Take a photo of anything else of significance (e.g. close up of lid lesion, side views for proptosis) OR IF NOTHING SIGNIFICANT take one picture of the patient SMILING (normal distance, vertically)
7. Make a note in the patient's chart by the slit lamp section that photos were taken with the iPhone/SmartPhone camera.
8. Circle External Photography (92285) on Superbill and link to diagnosis.

TONOPEN and ICARE TONOMETER – Indications for Use

<u>Indication</u>	<u>Tono-Pen</u>	<u>iCare</u>
1. Wheelchair patient	✓	✓
2. Difficult patient		✓
3. Red eye patient (if iCare is used, dispose of probe)	✓ (preferred)	
4. Patient refuses anesthetic drops		✓
5. Patient allergy/sensitive to anesthetic drops		✓
6. Corneal conditions (e.g. EBMD)		✓
7. Double check high Goldman reading	✓	✓
8. HIV/HSV/Hep C patient (if iCare is used, dispose of probe)	✓ (preferred)	
9. Serial tonometry		✓
10. House call/outside of office	✓	✓
11. Patient wearing bandage contact lens (-2 correction factor)		✓
12. Pregnant/nursing patient		✓
13. Tonometry post-visual field (performed by tech)		✓
14. IOP check directly after laser treatments	✓	✓

ICARE TONOMETER INSTRUCTIONS

- Use a tonometer probe from box in the ICARE case for each patient.
- When finished, before removal from ICARE unit, clean probe with alcohol.
- THEN, release cleaned probe directly in original tube.
- Place tube with used tonometer probe in container that says '**CLEANED ICARE PROBES**' in the case.
(THE PROBE NOR METAL STEM SHOULD NEVER BE TOUCHED)

Eyeglasses Complaint Checklist

Patient's Name: _____ Today's Date: _____

Chief Complaint (s):

☐ Blurry Vision at D OD OS OU ☐ Pt feels dizzy/ off balance ☐ Halos
☐ Blurry Vision at N OD OS OU ☐ Double Vision H V
☐ Other: _____

Date of New Eyeglasses _____ Date of Refraction _____

Type of Glasses: ☐ DV ☐ NV ☐ BIF ☐ TRI ☐ PRO ☐ Computer ☐ Other _____

New Frame? ☐ Yes ☐ No Does patient have old lenses or spectacles? ☐ Yes ☐ No

Name of Optical / Optician: _____

Did patient return to Optical/Optician to verify glasses? ☐ No ☐ Yes: _____

1. Has it been <u>less than 2 weeks</u> for the patient to adjust to the new Rx?	Y	N
2. Is the <u>lensometry</u> reading <u>different</u> from the most recent Rx in the chart?	Y	N
3. Has there been a <u>large</u> change in the _____ Sphere power?	Y	N
_____ Cylinder power?	Y	N
_____ Axis?	Y	N
4. Is there any <u>distance</u> or <u>near</u> prism being induced by the glasses? Slab-off calculator: http://www.robertsonoptical.com/slab-offcalculator.aspx	Y	N
5. Are the glasses fitted with proper _____ Vertex	Y	N
_____ Pantoscopic Tilt (normal 10-15°).	Y	N
_____ Face Form	Y	N
6. Is the Pt's VA <u>different</u> (OD OS) from the VA found at the last refraction?	Y	N

What do you think is causing this problem? _____

Plan:

- ☐ 1. Allow more time for patient to adjust to eyeglasses
- ☐ 2. Issue a new Rx informing optical of incorrect make
- ☐ 3. Issue a new Rx with instructions for "Doctors remake"
- ☐ 4. Have patient return to Optical with note to Align/Adjust glasses
- ☐ 5. Educate Pt that glasses/ prescription are correct and there is an underlying ocular problem
- ☐ 6. Other: _____

OS/OD: _____

***** ASK DR. WILLIAMS TO REVIEW ABOVE AND SEE PATIENT**

OD: AGREE WITH ABOVE: YES NO OD: _____

MD: AGREE WITH ABOVE: YES NO MD: _____

Trichiasis Epilation Protocol and Checklist

- ☐ Record any patient symptoms in CC/HPI section on exam form.
- ☐ Perform slit lamp exam. Identify and illustrate misdirected lash(es) on exam form.
 - a. When describing location of lash(es) on lid, be sure to identify location by right/left & upper/lower. Also, record how many lashes are present. For example, 2 lashes located on Right Lower Lid would be recorded as **RLLx2**.
 - b. Generally, an anesthetic drop (proparacaine) is instilled only if lash originates *inside* the lid margin – this area is more sensitive. Instill anesthetic drop in eye, if needed.
- ☐ Position patient in slit lamp, encouraging patient to keep forehead against forehead rest at all times.
- ☐ Have patient look away from area where epilation will occur.
- ☐ Gently rest hand on patient's cheek and pull lid up/down to expose lash to be epilated.
- ☐ Using *jeweler's forceps (which are kept in exam room top drawer)*, quickly remove the lash. Be sure to pull lash in direction opposite of the eye.
- ☐ Wipe forceps with clean tissue after each lash is epilated.
- ☐ Once procedure is complete, record impression and recommendation on exam form. Remember to describe location of lash(es) properly.

EXAMPLE:

Impression: 1) Trichiasis RLL, LUL

Recommendation: 1) Epilated cilia x 2 RLL, x 2 LUL

- ☐ **Update Problem List Sheet** with diagnosis and procedure.
- ☐ If needed, recommend/sample artificial tears. Record any samples given on exam form.
- ☐ On superbill, circle *diagnosis, Trichiasis H02.059 AND write modifier to specify which eyelid(s) (9=1 [RUL], 2 [RLL], 4 [LUL] and/or 5 [LLL])* in diagnosis codes. Also, circle *procedure, Trichiasis Epilation 67820* in minor surgery column and link to **CPT Modifier (E1=LUL, E2=LLL, E3=RUL, E4=RLL)**. Link the two codes by drawing a line.
SEE BACK for sample coding.
- ☐ NOTE: If the patient's primary reason for the visit is NOT trichiasis (for example, cataract follow-up), be sure to also circle SEPARATE E/M + PROC -25 under CPT MODIFIER and connect the modifier to the office visit.
- ☐ Wipe forceps with tissue and alcohol and replace in sleeve to be kept in exam room drawer for multiple use.

OS / OT: _____





MD / OD: _____

EYE CENTERS OF SOUTH FLORIDA (white) (D)

NAME: _____

TRICHIASIS EPILATION PROTOCOL (rev. 04/21/17)

DOB: _____ ACCT#: _____

EXTERNAL:	OD	No Change	OS	92285
- Lids				SI. Photo
- Lacrimal				
- Puncta				Ext Photo
	trichiasis RLL x 3 (temp), LUL x 2 (temp)			

DIAGNOSTIC IMPRESSION:			RECOMMENDATION:			90Day
Stable (S)	Better (B)	Worse (W)	CPM	Glasses	Med/Rx	Refills X
1	Trichiasis RLL, LUL		1	Epilated cilia RLL x 3, epilated		
2			2	cilia LUL x 2.		
3			3			
4			4			
5			5			

H02.054

CIRCLE CPT CODE 18

Check-in By:	Check-in Time:	Estimate Number:	Estimate Start Time:	Room/Room No:
OFFICE SERVICES - MP	MINOR SURGERY: RT LT	Pharyngitis (FE426)	65420	1500
OV L5 N5 (H205)	99205	250	AC Paracentesis	65900
OV L4 N4 (H204)	99204	225	Blower Eyelid Lesion	67610
EE NP Comp (H004)	92004	200	Chalazion x1 (FG800)	67800
OV L3 N3 (H203)	99203	175	Chalazion Multi (FG801)	67801
EE NP Inter (H002)	92002	150	Conjunctivitis Removal	68210
OV L2 N2 (H202)	99202	125	Conj Cyst Drainage	68520
OV L1 N1 (H201)	99201	100	Conj Lesion Exc - low	68110
OFFICE SERVICES - EP	Cornea Scrap/ Cull	66430	100	Custom Cataract
OV L5 E5 (H215)	99215	200	Cornea Epith. Removal	65435
EE EP Comp (H014)	92014	175	Excision Eyelid Lesion	67840
OV L4 E4 (H214)	99214	150	Excision Skin Tag	13200
EE EP Inter (H002)	92012	125	Excise Basal Cell 1-2 cm	11642
OV L3 E3 (H213)	99213	100	Excise Basal Cell 2-3 cm	11643
OV L2 E2 (H212)	99212	75	Eyelid Abcscs	67700
OV L1 E1 (H211)	99211	50	FB Removal Conj SL	65210
SPECIAL SERVICES	FB Removal Cornea SL	65222	100	CPT MODIFIERS:
Gonioscopy w/ OV G	92020	50	FB Removal Lacrims	66530
Ophthalm. Initial	92225	35	Lacrimal DMRage	68801-E
Ophthalm. Initial -50	92225-50	70	Lac Punctum Closure	66760-E
Ophthalm. FU	92226	35	Lac Punct. Occlude	66761-E
Ophthalm. FU -50	92226-50	70	Lac Punctum Plug	A4263
Serial Tonometry	92100	100	Prokera Insertion	65776
Courtesy Visit EP	CRTSY	0	Prokera Supply	V2750
Postop Exam PD	91024	0	Prokera Epithel	67620
Refraction (R1000)	92015G	50	Trich. Electrolysis	66825-E
RX Check classes RX	RXCHK	0	INJECTIONS: RT LT	Injection Subconj
DIAGNOSTIC SERVICES	Injection Subconj	67515	100	Injection Subconj
Adeno RPS (ADENO)	67800W	25		
A-Scan + IOL	76519	150		
IOL Calc only PC and	76516	50		
Bscan Ultrasound (B)	76512	150		
Corneal Topog.	92025	150		
Dial Fundus	92250	100		
External Photo	92285	50		
Fleur Angio	92235	100		
Fleur Angio OU -50	92235-50	200		
Inflammady- 1st eye	93916W	25		
Inflammady- 2nd eye	93916W99	25		
IOL Master + IOL calc	92136	100		
IOL Calc only -26	92136-26	50		
GCT Ant Segment	92132	50		
GCT Optic Nerve	92139	75		
GCT Macula GCA	92134	75		
Pachymetry	76514	25		
Spectator Endo Photo	92286	150		
TeerLab OD (TRLAB)	93916W99	25		
TeerLab OS (TRLAB)	93916W99	25		

CONTACT LENS EXTENDED HISTORY QUESTIONNAIRE

DATE: _____

Directions: Ask questions on form to all patients with Contact Lens Related complaints or problems.

1. What type of contact lenses do you wear?
☐ Soft ☐ Rigid/Gas Permeable/Hard ☐ Hybrid ☐
Single Vision ☐ MonoVision ☐ Bifocal ☐
Trifocal ☐ Multifocal ☐ Toric ☐ Scleral ☐
OrthoK/CRT ☐ Cosmetic ☐ Circle
☐ Other _____
2. What brand are your contact lenses? (See reverse side for full list) _____
3. How long using this brand? _____
4. What previous contact lens brands have you worn? _____
5. Why did you switch brands? _____
6. What replacement schedule are your lenses?
☐ Daily Disposables ☐ 2 weeks ☐ Monthly
☐ Other _____
7. How often do you actually replace your lenses?
☐ Daily ☐ 2 weeks ☐ Monthly ☐ Other _____
8. When was your last contact lens exam?
☐ Less than a year _____
☐ More than a year; How many years? _____
Eye Doctor's name: _____
9. How long have you worn contact lenses? _____
10. How old is your current pair of contact lenses? _____
11. Where do you usually buy your contact lenses? _____
12. How many hours a day do you wear your lenses? _____
13. How often do you sleep in your contact lenses? _____
14. How often do you shower in your contact lenses? _____

15. How often do you swim in your contact lens? _____

16. What do you use to clean your contact lenses?
☐ Optifree _____ ☐ Clear Care ☐ Renu
☐ Sauflon ☐ Boston ☐ Revitalens ☐ Aquify
☐ BioTrue ☐ Saline ☐ Whatever is on sale
☐ Other _____
How long using this brand? _____

17. How often do you clean your contact lenses?
☐ Every night (Daily) ☐ Weekly ☐ Monthly
☐ Never ☐ Other _____

18. Do you wash your hands before inserting and removing your contact lenses?

19. When cleaning, do you rub your lenses?
☐ Yes ☐ No (Educate on proper cleaning method)

20. Do you ever "top off" your contact lens solution in your case instead of completely replacing it?
☐ No ☐ Yes (Educate patient not to "top off")

18. How often do you replace your contact lens case?
☐ Monthly ☐ Other _____
☐ Never (Educate about monthly replacement)

19. Have you ever had any contact lens related eye problems or complications?
☐ No ☐ Yes, If so please explain: _____

20. Do you experience any of the following?:
☐ Cloudiness ☐ Pain ☐ Discharge ☐ Dryness
☐ Redness ☐ Itching ☐ Burning
☐ Gritty/Sandy ☐ Tearing ☐ Lens Rotation
☐ Fluctuating Vision ☐ Difficulty handling lenses
☐ Other: _____

21. Do you use any eye drops with your lenses?
☐ No ☐ Yes, Name: _____

22. Do you have backup glasses?
☐ Yes, How old are they? _____
☐ No (Educate on importance of backup Rx)

Note: Circle in RED the question numbers with Abnormal or Problem answers.

OT/OS _____ MD/OD _____

Refraction FAQ's

Everything you ever wanted to know about REFRACTION but were afraid to ask!

By Natasha and Krista

Refraction: All you need to know (as easy as 1-2-3)

1. Refract
2. Write the Script
3. Circle Refraction on the Superbill

*** But of course, there's a little bit more to know if you don't perform steps 1-2-3
So keep on reading until the end

Refraction Basics

1. What is a refraction?
 - a. The use of lenses to neutralize a patient's refractive error and finalize their glasses prescription.
2. How do I explain what a refraction is to the patient?
 - a. A refraction is a technique that the doctor uses to find your glasses prescription. It is the only way that the doctor will be able to write out a new/ updated prescription for your glasses.
3. When should a refraction be performed?
 - a. New patients? If the patient is not referred by an Optometrist (unless the patient has been referred for cataract and is not happy with their current glasses
 - b. Established patients? If the patient is not referred by an Optometrist and is not happy with their current glasses.
 - c. Post-op patients? 1 month post cataract surgery *If the patient is at our office for their post- op appointments it means that they are NOT being co-managed by their Optometrist, so we always do the refraction at this visit*
4. *Do we have a patient information sheet on refractive errors? No.*
 - a. *Maybe you can make that happen!*

Refraction Fees

1. Is there a fee for a refraction? Yes
2. What is the fee for the refraction? \$50.00
3. Do we have a form that explains the refraction fee to the patient? Yes.
 - a. It is given to all new patients to read and sign and is then placed in the chart on side A
 - b. It should also be given to all Long Return patients (1 year or more)
4. Should I bring up the refraction fee with the patient? No

Refraction FAQ's

PATIENT REFRACTION QUESTIONS AND EXTERN SCRIPTED ANSWERS

1. *What do I do if a patient asks me questions about the refraction fee?*
 - a. *PATIENT: Is there a fee?*
 - b. *EXTERN: I'm not sure. Please ask the doctor.*
 - i. **LEAVE A POST-IT FOR THE DOCTOR LETTING HIM KNOW THE PATIENT ASKED ABOUT THE FEE. PERFORM THE REFRACTION IF IT IS NEEDED OR IF THE PATIENTS WANTS TO LEAVE WITH A GLASSES PRESCRIPTION. THE DOCTOR WILL DECIDE IF HE WILL RELEASE THE PRESCRIPTION AND/OR CHARGE THE PATIENT.**
2. *What do I do if a patient asks me questions about refraction insurance coverage*
 - a. *PATIENT: Is it covered by my insurance?*
 - b. *EXTERN: I'm not sure. Please ask the doctor*

Refraction and Insurances

1. Does regular medical insurance cover refractions? Very rarely.
2. Does Medicare cover refractions? No
3. Does Medicaid cover refractions? Yes, but not always
4. Is there a type of insurance that covers refractions? Vision Plans generally will cover refractions
5. Do we have a list of Insurances that cover refractions? Yes.
 - a. Ask Dr. Hoffman for the list if you're interested. It is continuously updated

Refraction vs. Prescription

1. What is the difference between refracting and prescribing?

Refraction is used to FIND the patients updated prescription. We prescribe and give the prescription to the patient if it will help improve their vision, and when there is no medical/other reason not to.
2. When should I write out the prescription? Always write the prescription!!!
3. When should I recommend that the patient obtain new glasses? When there is a significant improvement in vision from the refraction or when the patient desires new glasses.
4. What is the name of a great book on prescribing? How to prescribe without making a spectacle of yourself. Mel Rubin. A copy is available in Dr Williams' office.

Refraction and OD Referred patients

1. Should I perform a routine refraction on OD Referred patients? No
1. When is it OK to perform a refraction on an OD referred patient?
 - a. New patients? When the patient insists on a prescription
 - i. Exception: You should always do a quick distance refraction on patients referred for cataract evaluation or posterior capsular haxe as this is needed to obtain prior authorization.

Refraction FAQ's

- b. Established patients? When the patient insists on a prescription or is no longer seeing that optometrist or the optometrist is no longer practicing (black X on the red sticker)
- c. Post-op patients? Always refract at the 1 month post-op visit because if the patient is here for their 1 month post-op appointment it means that they are not being co-managed by their optometrist (even if there is a red sticker on the chart)
- d. All patients: Only when the patient insists on having their refraction at our office.

Refraction and Post-Operative patients

- 1. How long after cataract surgery should I refract? 1 Month PO
- 2. How long after cataract surgery do we typically prescribe glasses? 1 Month PO
- 3. If both eyes are going to be operated on (cataract surgery) do you wait for both eyes to be done before refracting?
 - a. No.
 - b. A quick distance refraction or auto-refraction should be performed on the operated eye as this will help in the selection of the desired post-op refractive result of the second eye
- 4. Is the refraction included in the 90 day post-operative period? **No.** Make sure to circle "Refraction" on the super bill for all post- op patients. (Melody 4/28/2015)

Refraction and Unhappy patients

- 1. What should I do when a patient returns because they are unhappy with their new glasses?
 - a. Evaluate complaint and Fill in "New Glasses Complaint Assessment Worksheet"
- 2. Is there a special form that I should use? Yes, see above
- 3. General rules.
 - a. If possible, have the same extern that prescribed check the patient
 - b. Review with Dr. Williams if she is in the office.

Auto Refraction:

When do I perform auto refraction on patients?

- a. New patients? All comprehensive new patients
- b. Established patients? Every 12 months, or if the patient has visual complaints/wants new glasses. Or if best corrected vision is significantly decreased or if pinhole vision shows significant improvement.
- c. Post-op patients? 1 day PO if aim was not plano (Dr. Dan only)
1 week PO, 1 month PO (Dr. Dan and Hoffman)

Refraction related Patient Questions

- 1. Can I use this prescription for CL's
No. Explanation: Contact lenses require a special separate exam and must be fitted to your eyes.
- 2. Can I be fitted for CL's? No. Not at this visit. Dr. Hoffman/Dr. Dan does not fit CL's. Dr. Williams, our optometrist, can fit you with lenses at a later appointment.

Refraction FAQ's

3. Should I wear the glasses all the time? Wear the glasses whenever you want to see better (at near or distance based on prescription)
4. Where should I get these glasses? Your favorite Optician? The doctor will recommend someone.
5. Should I change all my glasses at the same time? NO, only one at the time.

Refraction Other related topics

1. What affects vision more, myopia or equal amounts of astigmatism?
 - a. Myopia, for every (-0.25D) of myopia it requires (-0.50D) of astigmatism to equally blur the patient
2. Is there a specific add that should be prescribed based on a certain age?
 - a. see age tables
3. When do you suggest OTC vs. NVO (lenses made by an optical)?
 - OTC readers can be suggested for a patient who does not have a distance Rx, or does not want a distance Rx
 - AND does not have a significant amount of astigmatism
 - AND does not medically require a special lens material or coating
4. What are the disadvantages of OTC Reading glasses?
 - cannot correct for astigmatism
 - only available in certain powers
 - cannot customize PD, may induce prism that can cause asthenopia when reading
 - Do not make a profit for the optometrist
 - May lose the patient for follow up
5. If a patient is wearing OTC readers and has complaints of asthenopia, how would you evaluate them to determine the cause of their complaint.
 - measure the patients PD
 - Measure the PD of the glasses
 - Measure the power of the glasses, is this the power that the patient should be wearing?
 - Is there enough induced prism to cause asthenopia?

Comments:

Please feel free to add any other questions or comments in the space below and return to Dr. Williams so that it can be updated as needed.

You can also email Dr. Hoffman with refraction questions or comments at jhoffman@myeyecenters.com or Dr. Williams at lwilliams@myeyecenters.com

DILATION FAQ

- **When should I dilate my patient?**

- All new patients should be dilated
 - Unless the patient declines or a specific cause prevents you from dilating the patient (see list below)
- Established patients should be dilated every 12 months.
- Established patients **with retinal conditions** should be dilated every **6** months
 - ARMD, diabetics, HIV+, patients on plaquenil, ethambutol, etc
- Established patients presenting with a problem that may indicate a new retinal condition
 - Flashes/Floaters, trauma, new amsler defect, sudden decrease in vision
- 1-week post-op YAG capsulotomy.
- 1-week and 4-week Cataract post-op patients if patient meets any of the following criteria:
 - Unable to view the fundus pre-operatively due to mature cataract
 - Signs and symptoms of retinal detachment
 - Pain or suspected endophthalmitis
 - Unexpected level of inflammation for post-op period
 - Unexplained decrease in BCVA
 - Intrasurgical complications (posterior capsule rupture or retained lens particles)

- **When should I NOT dilate?**

- IOP > 30
- Occludable angles
 - If angles appear narrow on Von Herick, perform gonioscopy or anterior segment OCT.
 - If you document on the chart that angles are grade 1 or !
- Patient is referred for “narrow angles”
- Infection
- Iris-supported IOLs (this does not mean an anterior chamber lens)

- **Relative Systemic Contraindications to dilation**

- Down's Syndrome
 - Avoid: cyclopentolate, scopolamine, homatropine and atropine
- Homocystinuria and Marfan's syndrome → Ectopia lentis
 - Dilate with caution with a weak mydriatic due to the risk of angle closure
 - Place in supine position during fundus assessment
 - After examination confirm that crystalline lens remains behind the iris and then mydriasis should be reversed using 0.5% dapiprazole
- Pregnancy and breast feeding
 - All drugs should be avoided if possible in first trimester
 - If dilation is necessary reduce systemic absorption pressing on the tear ducts after drop instillation

- **What drops should I use for a routine dilation?**

- For a brown iris
 - 1 drop of 1% Tropicamide or Paramyd
 - If poor dilation, you can add 1 drop of phenylephrine

- For a light iris
 - 1 drop of 1% Tropicamide or Paramyd
- **When I dilate a patient, how long do I tell them that it will take for their eyes to dilate:**
 - ALL patients should be told the same answer at ECOSF:
 - 30 minutes
- **When I dilate a patient, how long do I tell them that it will take for their eyes to go back to normal (if the patient asks) :**
 - ALL patients should be told the same answer at ECOSF:
 - Your eyes will stay dilated for 4-6 hours but in some cases, up to 24 hours.
- **Relative Contraindications Phenylephrine 2.5%:**
 - Do not use prior to evaluating ptosis
 - Caution with TCA, MAOI, methyl dopa, guanethidine, reserpine
 - Caution with history of cardiovascular disorder, arrhythmia, stroke, high blood pressure
 - Caution with narrow angles
 - Caution with hyperthyroidism
 - Because of increased sensitivity to circulating catecholamine's, hyperthyroidism patients may have an increased risk of adverse pressor effects from phenylephrine or hydroxyamphetamine.
- **When should I dilate only ONE eye?**
 - Post-op cataract surgery
 - Post-op YAG
 - Patient presents with trauma or uveitis in one eye and has been dilated OU within the last 12 months or 6 months with previous retinal findings
- **Dilating Pediatrics**
 - **Cycloplegic Refraction**
 - Instill one drop cyclopentolate twice 5 minutes apart
 - cyclopentolate 0.5% for children birth to 1 year
 - cyclopentolate 1% for older children > 1 year
 - Caution
 - Avoid overdosage in children with Down's Trisomy 13 and 18 (increased reaction to cycloplegics). Use Tropicamide 1%
 - Low Birth Weight

REMEMBER: DR HOFFMAN'S RULE = WHEN IN DOUBT, DILATE.