Optometrists & Opticians Board

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SUPERVISORY FRAMEWORK - OPTOMETRIST

Supervisee's Details:

Name : _____

Registration Number : _____

Registration Expiry Date : _____

Place of Practice : _____

Address of Practice : _____

_____

Supervisor's Details:

Onsite

Name : _____

Registration Number : _____

Place of Practice : _____

Address of Practice : _____

_____

CASE RECORD SUMMARY LOG

Case No.	Branch/ Patient Code No.	Condition/ Disease	Category Type*	Date of Visit
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

_____ _____

Signature of Supervisee / Date **Signature of Supervisor / Date**

***Category Type (select 5 out of 6 below):**

i) Contact lens fitting and management (follow-up)
ii) Contact lens complications
iii) Anterior ocular diseases: exclude pinguecula, naevus, arcus
iv) Posterior ocular diseases: excluding glaucoma
v) Glaucoma suspect
vi) Paediatrics (< 16 years)

Case no.: _____
Branch/Patient Code no.: _____
D.O.B: _____
Occupation: _____

CONSULTATION RECORD

GENERAL OPTOMETRIC EXAMINATION / CONTACT LENS COMPLICATIONS

Age/Race/Gender: _____

HISTORY

Date of visit _____

Chief complaint(s)

_____

_____

_____

Refractive /Optical Appliances Hx _____

Personal ocular health _____

Personal general health _____

Family ocular health _____

Family general health _____

Medications, Allergies _____

Visual Tasks _____

Other Observations _____

PRESENT SPECTACLE DETAILS

Date prescribed: …….. Type of lenses: …… Optical Centre (D / N): ……

	RE	**LE**
Distance prescription (VA)		
Near Add (VA @ __ cm) (if applicable)		
Reading prescription (VA @ __ cm) (if applicable)		

COLOUR VISION

Test _____

RE _____ LE_____

PUPILLARY ASSESSMENT

P E R R L A MG

REFRACTIVE ASSESSMENT

Patient's PD (D & N): ……

	RE	**LE**
Unaided VA (D/N)		
Objective Refraction (VA) Instrument: _____		
Subjective Refraction (VA)		
Near Add (VA@____cm)		
Pinhole VA (if applicable)		

VISUAL FIELD & OTHER TESTS (please **attach** result/chart if the following examinations are conducted)

	RE	**LE**
Confrontation/Perimetry		
Amsler		
Tonometry Instrument: _____ Time: _____		

BINOCULAR VISION

Cover Test (with Rx) *Including its magnitude and direction*	D					
	N					
Cover Test (without Rx – if applicable) *Including its magnitude and direction*	D					
	N					
NPC						
Ocular Motility						
Stereopsis (Type of test:_____)						
Amplitude of Accommodation		RE		LE		
AC/A Ratio						
Fusional Reserves	D	PFR		NFR		
	N	PFR		NFR		
Relative Accommodation	N	PRA		NRA		
Vergence Facility	Binocular					
Accommodative Facility	Monocular					
	Binocular					
Other Relevant BV Tests Test(s): _____						

ANTERIOR OCULAR HEALTH EXAMINATION
Please draw out relevant diagram below

RE	General
	Lids/Margins
	Conjunctiva
	Cornea
	Lens
	Iris
	Anterior Chamber
	Van Herick Angle
LE	General
	Lids/Margins
	Conjunctiva
	Cornea
	Lens
	Iris
	Anterior Chamber
	Van Herick Angle

POSTERIOR OCULAR HEALTH EXAMINATION
Please draw out relevant diagram below

RE	Disc colour, margin
	NRR
	C/D Ratio
	Retinal Vessels
	Mid Periphery
	Ocular Media
	Macula
	Fovea
LE	Disc colour, margin
	NRR
	C/D Ratio
	Retinal Vessels
	Mid Periphery
	Ocular Media
	Macula
	Fovea

PATIENT MANAGEMENT

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FOLLOW-UP ACTION(S)

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Signature and Name of Supervisee / Date

Signature and Name of Supervisor / Date

Case no.: _____
Branch/Patient Code no.: _____

FOLLOW-UP RECORD

FOLLOW-UP VISITS / SUPPLEMENTARY EXAMINATIONS

Purpose / Reasons of Visit

Date of visit _____

Case History (please include important info such as chief/presenting complaints and some other relevant info)

Present Visual Appliances Details (if applicable)

Examination Findings (please only include relevant examinations needed to be conducted)

Patient Management

Further Follow-up Plans / Case Closure

_____
Signature and Name of Supervisee / Date

_____
Signature and Name of Supervisor / Date

Case no.: _____

Branch/Patient Code no.: _____

D.O.B: _____

Occupation: _____

CONTACT LENS RECORD

CONTACT LENS FITTING & DELIVERY

Age/Race/Gender: _____

HISTORY

Date of visit _____

Chief complaint(s)

_____

_____

Refractive /CL Hx _____

Personal ocular health _____

Personal general health _____

Family ocular health _____

Family general health _____

Medications, Allergies _____

Visual Tasks _____

Other Observations _____

PRESENT SPECTACLE DETAILS

Date prescribed: …….... Type of lenses: …… Optical Centre (D / N): …….

	RE	**LE**
Distance prescription (VA)		
Near Add (VA @ __ cm)		
Reading prescription (VA @ __ cm) (if applicable)		

PRESENT CONTACT LENS DETAILS

Date prescribed		
VA (D/N)	RE	LE
Lens Details	RE	
	LE	

REFRACTIVE ASSESSMENT

Patient's PD (D & N): ..……

	RE	**LE**
Unaided VA (D/N)		
Objective Refraction (VA) Instrument: _____		
Subjective Refraction (VA)		
Near Add (VA@____cm)		
Pinhole VA (if applicable)		

KERATOMETRY & PUPIL SIZE

	RE	LE
Keratometry reading		
Pupil Size (bright/dim)		

Mire quality of keratomety (if applicable) ……..

ANTERIOR OCULAR HEALTH EXAMINATION

Please draw out relevant diagram below

RE	General
	Lids/Margins
	Conjunctiva
	Cornea
	Lens
	Iris
	Anterior Chamber
	Van Herick Angle
LE	General
	Lids/Margins
	Conjunctiva
	Cornea
	Lens
	Iris
	Anterior Chamber
	Van Herick Angle

1st TRIAL LENS FITTING (please illustrate the lens fitting below)

RE	**LE**

	Lens Details	
	Comfort	
	Coverage	
	Centration	
	Lag/Sag	
	Movement	
	VA (D/N)	
	Over Rx (VA)	
	Conclusion of lens fit	

2ND TRIAL LENS FITTING (please illustrate the lens fitting below)

RE	**LE**

	Lens Details	
	Comfort	
	Coverage	
	Centration	
	Lag/Sag	
	Movement	
	VA (D/N)	
	Over Rx (VA)	
	Conclusion of lens fit	

Remarks:

- Please use extra contact lens fitting form for 3rd or 4th trial fitting/subsequent trial fitting(s)
- Please **paste** the trial lenses foil if applicable (Do not staple the foil)
- Please attach results for other relevant tests (e.g.: topography etc) if applicable
- Please ensure that posterior ocular health has been assessed and no abnormalities detected. If there are abnormalities detected, please furnish the recording of posterior ocular health examinations in a separate recording sheets

FINAL LENS ORDERED:

Ordered Date:……

	RE	**LE**
Lens Details		
Reason(s) for final lens chosen		

Scheduled delivery date:……

CONTACT LENS DELIVERY/DISPENSING

Date dispensed	
Instructions/Advice	
Scheduled Aftercare Date	

Case no.: _____
Branch/Patient Code no.: _____
Date of Visit:……

AFTERCARE RECORD

CONTACT LENS AFTERCARE

CASE HISTORY

Chief/presenting complaints

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Patient's feedback on lens wear

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Patient's wearing modality

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Others important info

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LENS FITTING (please illustrate the lens fitting below)

RE		**LE**
	Lens Details	
	Comfort	
	Coverage	
	Centration	
	Lag/Sag	
	Movement	
	VA (D/N)	
	Over Rx (VA)	
	Conclusion of lens fit	

ANTERIOR OCULAR HEALTH EXAMINATION

Please draw out relevant diagram below

RE	General
	Lids/Margins
	Conjunctiva
	Cornea
LE	General
	Lids/Margins
	Conjunctiva
	Cornea

Patient Management

Further Follow-up Plans / Case Closure

Signature and Name of Supervisee / Date

Signature and Name of Supervisor / Date

Additional Form for Contact Lens Fitting(s)

_____ **TRIAL LENS FITTING** (please illustrate the lens fitting below)

RE		**LE**
	Lens Details	
	Comfort	
	Coverage	
	Centration	
	Lag/Sag	
	Movement	
	VA (D/N)	
	Over Rx (VA)	
	Conclusion of lens fit	

_____ **TRIAL LENS FITTING** (please illustrate the lens fitting below)

RE		**LE**
	Lens Details	
	Comfort	
	Coverage	
	Centration	
	Lag/Sag	
	Movement	
	VA (D/N)	
	Over Rx (VA)	
	Conclusion of lens fit	