Optometrists & Opticians Board

SUPERVISORY FRAMEWORK - OPTOMETRIST

Supervisee's Details:

Name : ______________________________

Registration No. : ______________________________

Registration Expiry Date : ______________________________

Place of Practice : ______________________________

Address of Practice : ______________________________

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Supervisor's Details:

Name : ______________________________

Registration No. : ______________________________

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 at least 5 out of 6 below):**

i) Contact Lens Fitting and Management (Follow-up)
ii) Contact Lens Complications
iii) Anterior Ocular Diseases
iv) Posterior Ocular Diseases (exclude glaucoma)
v) Glaucoma Suspect
vi) Binocular Vision Dysfunction

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 Use ____

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: ..……….

	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

Pupillary Distance (Distance & Near): ..……………

	RE	LE
Unaided VA (D/N)		
Objective Refraction (VA) Instrument: ________________		
Subjective Refraction (VA)		
Near Add (VA @ ___ cm)		
Pinhole VA (if applicable)		

*Note: Please indicate "**NA**" if any of the following tests is not applicable. If the test is conducted, **attach** the result/chart if*

VISUAL FIELD & OTHER TESTS

	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, or to include photo-documentation with labels

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, or to include photo-documentation with labels

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

FOLLOW-UP ACTION(S)

Signature & Name of Supervisee / Date

Signature & 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 other relevant info)

Present Optical Appliances/CL 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

CONTACT LENS RECORD

CONTACT LENS FITTING & DELIVERY

Case no.: ____________
Branch/Patient Code no.: ______________________
D.O.B: ____________________________
Occupation: ________________________ Age/Race/Gender:______________________________

HISTORY Date of Visit ____________________

Chief Complaint(s)

____

____

Optical Appliances/CL Use ____

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: …………

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

PRESENT CONTACT LENS DETAILS

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

REFRACTIVE ASSESSMENT

Pupillary Distance (Distance & Near): ..……………

	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 Keratometry (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

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 any subsequent trial fitting(s).
- Please **paste** the trial lens foil, if applicable (do not staple the foil).
- Please attach results for other relevant tests, such as topography etc, if applicable.
- Please ensure that posterior ocular health has been assessed and no abnormalities detected. If there are abnormalities detected, the findings shall be recorded in a separate recording sheet.

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

HISTORY

Chief/Presenting Complaint(s)

……
……
……

Patient's Feedback on Lens Wear

……
……
……

Patient's Wearing Modality

……
……
……

Others Important Info

……
……
……

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, or to include photo-documentation with labels

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	