

The i-Clarity Clinical Records module consists of 4 record types: Pre-Screening, Clinical Records, CL Records and Other.

Note that patient information in the Clinical Records module is more sensitive than that stored in other parts of the system. It is strongly recommended that you use Maintenance/Form Permissions to create a user group for registered staff. You can then assign your professional staff to that group and ensure that only they have access to the full clinical records forms ((CL Clinical Records, Clinical Records and optionally Other Exam).

Minus Cyl vs Plus Cyl

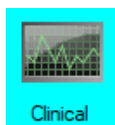
Throughout i-Clarity the system defaults to either plus cyl or minus cyl according to the preference of the logged in user. This is set in the User tab of maintenance.

Pre-Screening

The Pre-Screening module is intended for those practice that have facilities for member of staff other than the Optometrist to start the examination process outside the test room. It allows an optical assistant to gather initial information allowing the Optometrist more time to concentrate on the examination and refraction.

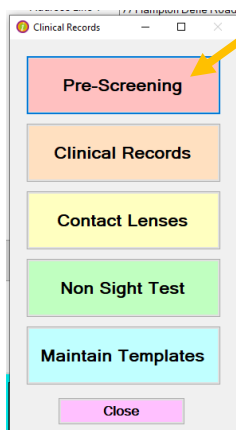
If you are using the pre-screening in your practice you should complete the pre-screening form before the full eye examination, otherwise there is the possibility that data entered into the full record will be overwritten by information from the pre-screening.

To open the Pre-Screening.



Click on the Clinical icon.

This will open the clinical menu.



Click on the Pre-Screening button.

This will open the Pre-Screening form for the active patient.

Pre-Screening: Miss Kathryn Homayounfar

Specs History

Purchased	Condition	Spec Type	Prescription	Notes

Average Bifocal

Objective

Right Sph Cyl Axis Dist PD BVD

Left Sph Cyl Axis Dist PD BVD

R Pachymetry: L Pachymetry:

Pressures

Date	Machine	Right	Left

Reason For Visit / Pre-Screen Notes

Reasons for Visit: <<RFV>>
 Hobbies/Interests: <<Interests>>
 Contact Lens Wear: <<CLWear>>
 Driver: <<Yes/No>> VDU Use: <<Yes/No>> Smoker: <<Smoker>>

Patient's Occupation:

Date	RRad1	RAxis1	RRad2	RAxis2	LRad1	LAxis1	LRad2	LAxis2

Examination Date: 19 Aug 2019
 Staff Member: Mr Rob Ward
 Type: Private

The behaviour and use of each of the pre-screening fields is described below.

Spec History

This is where the user can enter details of any pairs of spectacles that the patient may have.

1. Enter the date purchased (this must be a date in the form d/m/yy, but of course the patient may not remember so a date like '1/1/2016' will usually be sufficient); the condition, the type of spectacles and frame description, as shown below, then click Add:
2. When the spectacles have been added to the grid, you can then double click on the prescription column and enter details of the prescription:

Note 1: These details can be automatically imported from a connected, compatible focimeter by clicking the 'Import Instrument Data' button.

Note 2: Even if you are not using the Pre-Screen module, staff can still use the same functionality to add details of spectacles even while an examination is in progress. This is accessed from the 'Further Details' tab of the main patient form, by clicking the 'Spectacle History' button.

Objective

You can enter details of the objective Rx in the appropriate boxed in the Objective section of the form:

Objective		+	-	+	-	+	-	
		Sph		Cyl		Axis	Dist PD	BVD
Right		+2.00	/	+0.50				
Left		Bal	/					

Transpose

These values can also be entered automatically from a compatible, connected autorefractor, by clicking the 'Import Instrument Data' button.

If the spherical powers have different signs then these fields are highlighted in pink, like this:

	Sph
Right	+1.00
Left	-1.00

Pachymetry

Enter the R and L values in the fields provided.

These may also be imported automatically from a compatible instrument, e.g. a Topcon TRK-2P.

Pressures

There is no need to enter the Date field, as i-Clarity will default to the current date and time (although you can if you wish, e.g. when entering pressures that were recorded previously.)

You then select the instrument from the instrument dropdown.

This can be configured so the list only displays the instruments that are used in your practice (Maintenance/Misc 5 tab), and also can default to the instrument most commonly used in the current test room, defined in Computer tab of maintenance, the Tonometer column.

You can then type in the R and L *average* values and click Add. Alternatively, by clicking the More Detail button you can add up to 3 values for each eye; only the average will be displayed but the constituent values will be retained.

Reasons For Visit/Pre Screen Notes

This is a text field, that can be completely blank so that you can free type whatever you want into it.

Alternatively, you can use pre-created templates that have appropriate questions and (optionally) 'tags' – defined by right and left chevrons like these: << >> - that allow you to select from predefined lists of answers.

Templates come in two forms, either *Generic* – that is, they are usable by all members of the practice, or *Individual* – they are specific to the currently logged in user.



Templates can be selected by clicking the down arrow; this will give you the choice of selecting from the list of generic templates or your own, personal ones. Note that each user can set a template to be the default that is used in this field, by selecting the User from the User tab in Maintenance, and pressing the 'Set Up Default Clinical Templates' button; if you do this then you only have to select a template if you want to use a different one from the default, (e.g. if you have a different template for a child rather than an adult.)

You can either free type into the Reasons for Visit field or if you are using templates with tags, select from pre-defined lists of answers. This is shown in the following illustration:

The screenshot shows a software interface for 'Reason For Visit / Pre-Screen'. It includes fields for 'Reasons for Visit <<RFV>>', 'Hobbies/Interests: <<Interests>>', 'Contact Lens Wear: <<CLWear>>', and 'Driver: <<Yes/No>> VDU Use: <<V>>'. Below these are buttons for 'Remove All Tags', 'Show History and Presenting VAs', and a table with columns 'Date', 'RRad1', and 'RA'. A date dropdown shows '19 August 2019'. Overlaid on this is a 'Tag Answers' dialog box. The dialog has a 'Search Answers:' field and a list of pre-defined answers. The 'Selected Answer:' field shows 'Blurred near vision , Floaters'. Buttons at the bottom of the dialog include 'Add This Answer', 'OK', and 'Cancel'.

You can move to each tag by pressing the Tab key on your keyboard (that will automatically move the insertion point, firstly to the next colon (:) , and then into the following tag; you can then list the pre-defined answers by right clicking one or more of the pre-defined answers, then pressing 'OK'.

Once you have entered your answer(s) you can then edit them in the field or tab to the next tag (or simply move to it with your mouse).

(Template and tag maintenance are described in the Maintenance section at the end of this chapter.)

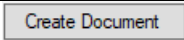
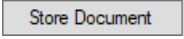
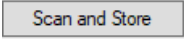
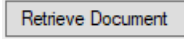
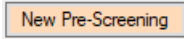
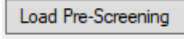
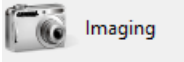
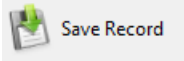
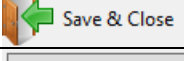
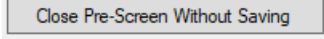

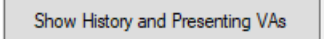
Patient's Occupation

This allows you to specify the patient's occupation from the pre-defined list of occupations. This updates the main patient record and also appears on the title bar of the Clinical Records forms.

K Readings

This allows you to enter the K readings – these are also fields that can also be added automatically from a compatible and connected device, e.g. a Topcon TRK-2P.

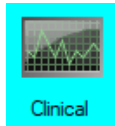
Pre-Screening Form – Buttons

Button	Function
	This allows you to select a predefined template (e.g. a Word document or email template) and create a communication completed with details from the patient record. A copy of each communication generated here will be saved with the patient record.
	This allows you to save documents with the patient record that haven't been created by i-Clarity, e.g. letters from GPs, responses to referrals, fields etc. The relevant document should first be saved in a folder that is accessible to this PC, then you click this button, select the document, select the folder that you wish to save the document in, and click OK.
	If you have a compatible scanner this allows you to directly scan the document (single page only) by placing the document on the scanner then clicking this button. This will start the scanning process automatically so you then just need to choose the appropriate patient folder to store it in.
	This allows you to retrieve and display any patient documents created or stored using the procedures described above.
	Once you have created a Pre-Screen record, whenever you access the Pre-Screen form the system displays the most recent record. When you want to create a new record, click this button.
	This allows you to load a previous Pre-Screen record, select the record you want from the
	This allows you to access the i-Clarity Imaging menu, which in turns allows you to take, store and review imaging data from a variety of different systems including fundus cameras, slit lamps and OCTs. (See the discussion of Imaging at the end of this chapter for further details of this.)
	This allows you to save the current record then continue working on it.
 Date: 19/Aug/2019	This allows you to save the current record then quit this module.
	This allows you to quit this module WITHOUT saving any changes that you may have made.
	Once you have completed a Pre-Screen record, this button allows you to remove any tags that you haven't used, to improve the legibility of the finished record.
	This option is more commonly used in jurisdictions outside the UK. It allows the staff member who is using the Pre-Screening module to add details of general health, ocular history, family history and medication, also presenting VA. See the Clinical Records module for more details of this.

<div data-bbox="204 152 472 192" data-label="Text"> Import Instrument Data </div>	This allows you to import data from connected compatible instruments to the appropriate fields, e.g. specs Rx from a focimeter, pressures from a tonometer, objective from an autorefractor etc.
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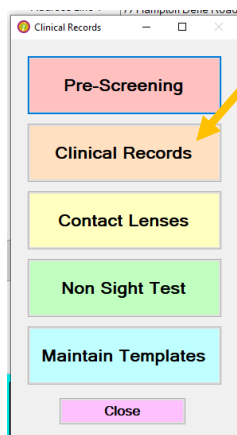
Once you have completed the Pre-Screen record then click Save & Close; this will save all the latest data and return you to the main patient form.

Clinical Records



The Clinical Record is accessed by pressing the Clinical button on the Main Patient form.

Then selecting Clinical Records from the menu.



The first time you access the form for each patient you are presented with a blank clinical record; once you have created a patient's clinical record then the most recent is displayed.

A new clinical record looks like this:

It is designed to be both completed and then read from the top left to the bottom right, following the 'natural' flow of information and the narrative arc of a 'typical' examination. Each of the data sections are listed in more detail below.

Once you start entering data into the Clinical Records field, the data will be automatically saved every 5 minutes; so even if your system has an outage, e.g. a power cut, then the most you will lose is any data entered in the previous 5 minutes – of course, if the power cut occurs just after the automatic save has occurred then you won't lose any data at all.

Protecting your records – the i-Clarity Audit File

On both a personal and practice level, your clinical records contain the most important and irreplaceable information that you hold on your computer system. As well as using them day to day for normal clinical and dispensing purposes, you need to be able to have access to them *outside* i-Clarity for a number of other reasons. Some of these are listed below:

- Provide patients with a copy of their records
- Provide copies to ophthalmologists or other optometrists
- Provide lawyers or the GOC copies in the event of a dispute or FTP hearing
- i-Clarity not working or no longer being maintained or rented

To cover all these eventualities i-Clarity automatically creates a human-readable pdf 'Audit File' of each patient's clinical record whenever that is created or updated. More precisely, and to avoid the number of these audit files becoming unmanageably large, it creates 1 audit file per patient per day. This is updated every time the patient record is updated on the same day. If the patient record is updated at a later date, then a new audit file is created.

These files are stored in the 'Audits' subfolder of each patient's Windows folder in the location specified in the Branch tab of Maintenance, the **Px Folders** field.

Each file is cumulative i.e. it contains all the clinical data, including data from previous visits, that was stored up to the point that the file was created.


Note: The point of these files is that they ARE human readable, so you should ensure that your computer network is sufficiently secure, and that you have appropriate protocols in place, to prevent these files being accessed by unauthorised persons.

Using Templates and Tags

Several fields in the clinical record can be populated with templates that in turn can either be specific to the current user or 'generic' and used by all users within the practice.

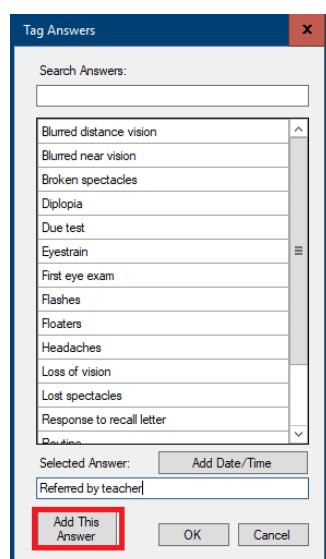
The two fields in the Clinical Record that can contain templates are Main Reasons For Visit/Initial Patient Notes field, and the Right Notes/Left Notes fields.

You can select the template you want to use in each of these fields by clicking on the down

arrow that is visible when that field is *not* selected:  This will allow you to select from either the 'Generic' (practice wide) templates, or those that you have created for your own use – 'My Templates'.

In addition you can set default templates for these two fields. This is done in Maintenance; select the User from the User tab in Maintenance, and press the 'Set Up Default Clinical Templates' button, and chose what templates you want as the default for each field that can accept a template. If you do this then you only have to select a template if you want to use a different one from the default, (e.g. if you have a different template for a child rather than an adult.)

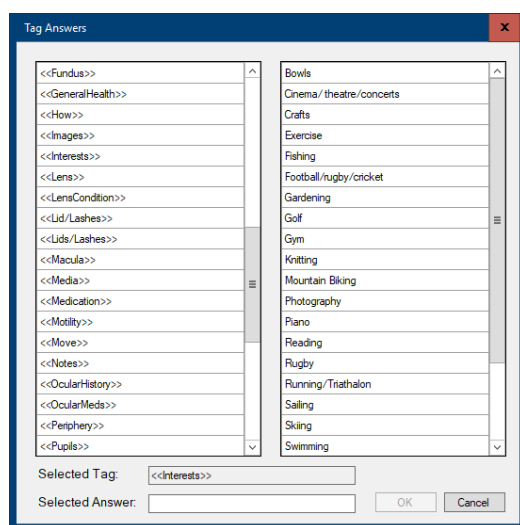
Templates can simply contain text, to identify data items that you need to enter, or can contain 'tags', identified with pairs of chevrons: <<>>. By right clicking on a tag you can then access a list of predefined answers from which you can select one or more then replace the selected tag with them:



Even when you have used tags, you can still free-type additional information or edit the existing answer.

Note in the example above you can enter additional answers 'on the fly', by typing in the new answer you want then clicking 'Add This Answer'. This will both insert the selected answer into the record and add it to your list of personal answers for the selected tag. This feature can be disabled if required, (Misc 5 tab in Maintenance, 'Allow Adding Tags on the Fly').

If you have selected answers from the Tag Answer form and clicked OK, then the above dialog disappears. If you want to bring it back, e.g. because you want to add further answers to those you have already selected, the you can press CTRL + ALT + T – this will bring up the list of all possible tags, and once you have selected one in the left hand list box the list of possible answers will appear on the right, as shown in the example below:



A number of fields e.g. General Health and Dispensing Notes do not use templates but still contain tags, so you can save typing in these fields by predefining your answers and just selecting the text you want.

(Maintaining templates and tags is described later at the end of this chapter.)

Clinical Records Fields

Previous Rx

Previous RX		Patient's Ethnicity	Unknown
22/05/2009	Right: 6/6- Plano/-0.25 x 180 VA:6/6 NVA:N5 Left: 6/6+ +0.25/-0.25 x 180 VA:6/6 NVA:N5		
15/03/2008	Right: 6/6+ +0.25/+0.00 VA:6/6+ NVA:N5 Left: 6/6 +0.25/-0.25 x 180 VA:6/6+ NVA:N5		

The patient's previous prescriptions are displayed here, in descending order of date. These are the prescriptions that can be viewed from the summary Rx form on the main patient form,



accessed using this button:

Note that you can also enter Rx's in the summary form, and this is how we recommend you enter prescriptions bought in from other opticians. When the full Clinical Record module is enabled, the default test type for a new Rx in the summary form is therefore set to 'Test Elsewhere'.

When starting to use the Clinical Records module, you may find it useful to have support staff key in the most recent Rx in the summary form prior to the examination, as the details can then be copied from this previous Rx to the new Objective and/or Subjective fields in the latest record.

Main Reasons for Visit/Initial Patient Notes

Main Reasons for Visit / Initial Patient Notes	
Reasons for Visit: <<RFV>>	<div><div>A</div><div>A</div><div></div><div></div></div>
Hobbies/Interests: <<Interests>>	
Contact Lens Wear: <<CLWear>>	
Driver: <<Yes/No>> VDU Use: <<Yes/No>> Smoker: <<Smoker>>	

This is a text field that can be completed in one of 4 ways:

- If your practice is using the Pre-Screen form, then the details can – and should - be copied from the most recent Pre-Screen using this button, found on the bottom right of

the form: 

- You can simply free type the information.
- You can set a default template for this field, (see the section above, 'Using Templates and Tags' how to do this)
- You can select a different template from the list of Personal and Generic templates by

clicking the down arrow: 

Whichever method you choose you can edit the contents at any stage.

Unaided and Presenting VA

	Unaided			Presenting VA			Specs Note
	R	L	Bin	R	L	Bin	
Dist.	6/15	6/15	6/12	6/9	6/9	6/7.6	OF 2080 with MAR SV
Near	N24	N24	N18	N8	N8	N6-	+1.00 ready readers

This where you record what the patient can see without and with their current spectacles. There is also space to record which glasses the patient was wearing when they achieved those results. Note that the VAs entered here also appear in non-editable greyed out boxes against the Object, Subjective and Final Rx fields.

Note that you can specify the default scale used by each user, ('6/' and 'N' in the above example). This is specified in Maintenance/Users.

General Health/Ocular History/Family History/Medication

General Health <<GeneralHealth>>	Ocular History <<OcularHistory>> A A
Family History <<FamilyHistory>>	Medication <<Medication>>

These 4 boxes all come pre-populated with tags so you can predefine possible answers, (see the section on Maintenance at the end of this chapter how to do this.)

In the list of possible answers for the <<FamilyHistory>> tag, we recommend predefining family members – e.g. Mother, Father, Grandfather – as well as possible conditions, e.g. Glaucoma, diabetes, low vision etc. That way you can select a family member and the condition(s) that were associated with them.

When you select the <<Medication>> tag, the possible tag answers dialog is slightly different, as it allows you to enter a medical condition, and then just display those medicines that are appropriate for the selected condition, as shown in the following example:

The dialog box titled 'Tag Answers' has a search bar and a filter dropdown set to 'Systemic hypertension'. A list of medications is displayed: Amoxicillin, Aspirin, Clopidogrel, Ramipril, and Warfarin sodium. At the bottom, there is a 'Selected Answer' field, an 'Add Date/Time' button, and 'Add This Answer', 'OK', and 'Cancel' buttons.

Note 1: The contents of each of these boxes is always copied forward to the next clinical record, and a new tag added to the existing content. Here is an example where a new patient record has been created for a patient, who in her last visited recorded the fact that she suffered from the conditions shown:

General Health
Asthma , Eczema , Hayfever <<GeneralHealth>>

You can then add to these conditions or delete any that no longer apply.

Note 2: All clinical record data is by default output to a PDF file. This means that you can always read a patient's clinical data, even if i-Clarity is no longer installed. It also means that you can send the entire clinical record to a 3rd party if required, e.g. the GOC or an ophthalmologist. However we cannot guarantee the security of these audit files, as they are stored in Windows folders, and so their security is a function of your network setup/infrastructure. If there is information in these boxes that is of a particularly sensitive nature, then this can be excluded from the audit files by clicking the Mark as Confidential flag below the Medication field:

☐ Mark as Confidential

Pachymetry

R Pachymetry: L Pachymetry: Previous Pachymetry

You can enter pachymetry readings here; alternatively they can be imported from a Pre-Screen record, or imported from a connected and compatible instrument.

The Previous Pachymetry button will display previous pachymetry values.

Pressures

Pressures	Instrument	R 1	R 2	R 3	R Av	L 1	L 2	L 3	L Av
16/Aug/2019 14:24	Goldmann	11.0	11.0	12.0	11.3	11.0	13.0	12.0	12.0
16/Aug/2019 14:23	Pulsair Easy Eye	11.0	12.0	13.0	12.0	11.0	11.0	11.0	11.0
<input type="text"/>	I-Care	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Pressures can be entered in one of 3 ways:

- 1) From the Pre-Screen form, described above.
- 2) By importing from a connected compatible instrument.
- 3) By typing the values in in the test room. This is described below:

There is no need to enter the Date field, as i-Clarity will default to the current date and time (although you can if you wish, e.g. if you want to enter pressures that were recorded previously.)

You then select the instrument from the instrument dropdown. This should be configured so the list only displays the instruments that are used in your practice (Maintenance/Misc 5 tab), and also can default to the instrument most commonly used in the current test room, defined in Maintenance/Computer tab, the Tonometer column.

You can then type in 3 values for the R and L, or just enter the average figures in the 'R Av' and 'L Av' columns; and click Add.

Note the pressures records aren't linked to a specific clinical episode, so you can enter pressures on different days without having to create an entire new clinical record.

Spec History

Spec History	Condition	Spec Type	Prescription	Notes
01/Jan/2018	Aver...	Dist...	R: +2.00/+0.50 x 32 L: +2.00	Fendi
	Average	Bifocal		<input type="button" value="Add"/> <input type="button" value="Delete"/>

Entering spectacle details is described in detail in the Specs History section of the Pre-Screen form.

Note that when spectacles are dispensed using i-Clarity, they will automatically be added to this list once those spectacles have been collected by the patient – and a note to that effect is displayed when you next access the Clinical record.






Also, to avoid the list becoming unmanageably long, you can remove spectacles from the list that are no longer relevant when reviewing the patient history. Highlight the pair that you no longer wish to display and press the Delete button. This only removes the pair from this list – the details will still be stored in the Sales and Orders forms of the patient record.

Right Notes/Left Notes


Right Notes	Left Notes
Pupils: <<Pupils>> External: <<ExtEye>> Anterior: <<Anterior>>, VH: Cornea: <<Cornea>> Conjunctiva: <<Conj>> Vitreous: <<Vitreous>> Lens: <<Lens>> Disc: <<Disc>> Vessels: <<Vessels>> Macula: <<Macula>> Fundus: <<Fundus>> Drops: <<Drops>>	Pupils: <<Pupils>> External: <<ExtEye>> Anterior: <<Anterior>>, VH: Cornea: <<Cornea>> Conjunctiva: <<Conj>> Vitreous: <<Vitreous>> Lens: <<Lens>> Disc: <<Disc>> Vessels: <<Vessels>> Macula: <<Macula>> Fundus: <<Fundus>> Drops: <<Drops>>
Cover Test: <<Cover>> Motility: <<Motility>> NPC: cm. Accom: D. Fields: <<Fields>>	

This is where you enter details of the examination itself. Although you can free type in the relevant boxes it is highly recommended that you create templates that contain prompts and tags for the procedure that you want to follow.

There are six buttons that are displayed when the Notes part of the Clinical Record form is NOT selected (i.e. you have not clicked in to one of the three boxes. These are each described below:

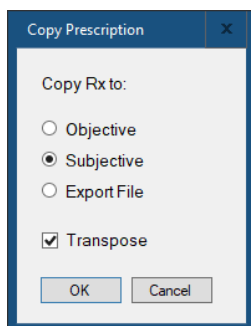
	This allows you to copy the contents of these three boxes from the previous clinical record. You can then edit and update the contents. You must do this before you start entering new details as this action will overwrite the contents of all 3 boxes.
	This copies the contents of the Right notes field into the Left notes field – again, take care because this action will <i>overwrite</i> the contents of the Left notes field so you should do this before you start amending the contents.
	These buttons allow you to change the size of the text. The size you choose will be retained when you save the record. Note that you can specify the default text size for each user, by selecting the User tab in Maintenance and entering the default font size in the Font Size column. (The default is 10).
	This allows you to select the appropriate template for this examination, or a different one from the default if a default is defined for the current user. <i>Note that you should choose your template BEFORE you start entering data – selecting a new template will overwrite any data that you may have already entered.</i>
	These buttons allow you to reduce or expand the size of the notes window so that you can see or hide the Objective and Subjective refraction details. If you usually prefer to see refraction details, and therefore see a smaller Notes field, this can be set as a default in the User tab of Maintenance, by ticking the 'Obj Subj' flag for the selected user.

Objective Rx

Objective RX		+	-	+	-	+	-								
	Vision	Sph		Cyl	Axis	Dist Prism	V/A	Add	Nr Prism	N V/A	Int Add	BVD	Dist PD		
	R 6/15	Bal	/												
	L 6/15	Bal	/												

You can enter information into the Objective part of the examination in 4 ways:

- 1) By typing the values in directly – if you use the Tab key then the insertion point will move to each box in turn. Once you have entered a value, e.g. cyl of 0.25, then you can 'tweak' this value by clicking the + or – symbols above the relevant column.
- 2) By importing the data from a compatible, connected instrument such as an autorefractor.
- 3) By copying the relevant values from a previous Rx, displayed in the top left of the form. Select the Rx that you wish to copy by double clicking the grey box to the left of the Rx and you will then be presented with the following dialog:



You can then copy the relevant fields from the selected Rx to the relevant Refraction. Note that you can transpose the Rx at this point; if the original Rx is in a different form from the default for the current user the Transpose option is automatically selected. Also, there is an option to Export the relevant data to a file; this is so the information can be picked up by a compatible, connected instrument such as a phoropter.

- 4) The same functionality is also available using the prescriptions stored in the Spec History form; just double click on the Spectacles you wish to use and you will be resented with the same dialog as above. (This is a good reason to ensure spectacles have been neutralised before you start refracting the patient.)

There is room for recording BVD and PDs against the Objective, however the PD field is a memo field only, and is NOT copied to either the Summary Rx form or the Dispensing form. This is by design.


As in the Pre-Screen form, if the spherical powers have different signs then the sphere fields are

	Sph
Right	+1.00
Left	-1.00

highlighted in pink, as shown here: . This highlighting occurs in all 3 Rx fields.

The down arrow button to the left of the Rx  will copy the objective to the subjective Rx, which is described below.

Subjective Rx

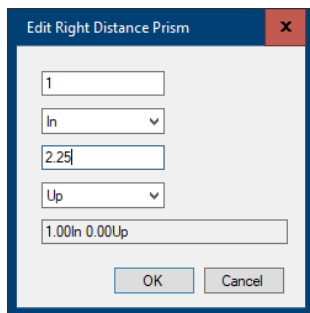
Subjective RX		+	-	+	-	+	-	Copy Prisms >>		+	-	+	-	PH	
	R 6/15	-0.25	/	+0.25	90					+0.00				+0.00	
	L 6/15	Plano	/	+0.25	90					+0.00				+0.00	

The subjective Rx can be populated in the same 4 ways that the objective can be, with the additional method that it can also be copied from the objective Rx on the same record.

There are a number of additional fields associated with the Subjective, these are:

- Distance and near prism
- Add
- V/A and Near V/A
- Pinhole

To enter prims, click in the relevant field and you will be presented with the following dialog:



Dialog box titled "Edit Right Distance Prism". It contains the following fields and controls:

- A text input field with the value "1".
- A dropdown menu with "In" selected.
- A text input field with the value "2.25".
- A dropdown menu with "Up" selected.
- A text input field with the value "1.00In 0.00Up".
- "OK" and "Cancel" buttons at the bottom.


Enter the appropriate values and select the direction from the two drop downs, and click OK to save.

Once you have entered details of a distance prism, this can be copied to the near prism field by clicking this button: [Copy Prisms >>](#) . They can then be edited if required by clicking into the field.

Final Rx

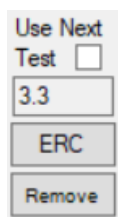
	Nr Vis	Final RX	+	-	+	-	+	-	Copy Prisms >>	+	-	+	-
R	N24	6/15	Bal	/						+0.00		+0.00	
L	N24	6/15	Bal	/						+0.00		+0.00	
B	N18	6/12		/									

This can be populated in 3 ways:

- 1) By typing in the values directly
- 2) By importing from a compatible and connected phoropter
- 3) By copying from the subjective Rx, by clicking the  button that is to the left of the Subjective.

This Final Rx is the Rx that is displayed at the top left of the form; it is also used to populate the summary Rx form that is accessed from the main patient form, and is therefore the Rx used as the basis for dispensing.

Early Recall Code



By clicking on the ERC (Early Recall Code) you can select the reason that you have seen this patient earlier than would normally be allowed.

If you are going to recall the patient for an examination earlier than recommended by the NHS (meaning you will need to apply an early recall code at the next examination) then you can tick the box 'use next test'. At the next examination i-Clarity will prompt you to apply an ERC.

Clinical Notes/Exam Outcome

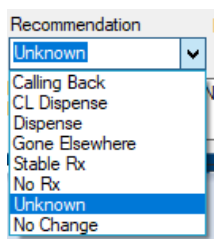


This is intended as a narrative summary of the examination, e.g. 'New Rx issued, recommended specs updated, gave leaflet on smoking, referred to GP'... You can pre-define possible answers using the <<ExamOutcome>> tag, freetype your summary, or a mixture of both.

The information in this field is available as a merge field, so can be used to create a standard document, e.g. a patient prescription that includes the summary outcome.

Be aware that this information is also displayed on the Summary Rx form, so you should not use this field to record information of a sensitive nature.

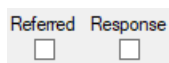
Recommendation



This allows you to record what you believe the outcome of the examination should be; e.g. you believe that the patient should be dispensed new glasses, but of course you cannot ensure that they were.

This information is particularly useful for reviewing clinic outcomes. In the Clinic Outcome report, only option 'No Rx' is excluded from the total of tests that might be considered 'Dispensible.'

Referred/Response

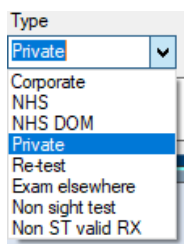
A snippet of a form with two columns: 'Referred' and 'Response'. Each column has a small square checkbox below it.

This allows you to record whether you need to refer a patient or not – and also whether a response was received. You can find the list of patients who have been referred in the report 'Referral Responses' from the main Report menu.

If you tick the referred flag this also automatically creates an Action, assigned to you, in the Patient Activity tab. This means that if you don't have the time to do the referral there and then, you will see that you have actions outstanding whenever you log in to i-Clarity. This is shown in

the top right hand corner of the main form, like this: You have 1 actions outstanding - double click on this message and you will see the outstanding action list.

Type

A screenshot of a dropdown menu titled 'Type'. The menu is open, showing several options: 'Private' (highlighted in blue), 'Corporate', 'NHS', 'NHS DOM', 'Re-test', 'Exam elsewhere', 'Non sight test', and 'Non ST valid RX'.

This is where you select what type of examination you have conducted. The options are shown below. Note that you will have the opportunity to change these before you finally confirm the examination details, as described in the following section, 'Confirming Examination Details.'

Type	Description
Corporate	This is intended for examinations undertaken for 3 rd parties, e.g. for a local authority or fire brigade. The refraction will be considered valid so will be available for dispensing; you will need to add an appropriate fee when you confirm details in the 'Confirming Examination Details' form (see below for further details).
NHS	This is for 'standard' NHS eye examinations and will add an examination fee of the type 'NHS_Fee' to the patient sale. This will be selected by default if an NHS reason has been defined for this patient on the main form.
NHS Dom	This is for a domiciliary NHS eye examination and will add an examination fee of the type 'NHS_Dom' to the patient sale.
Private	This is for standard Private eye examinations and will add an examination fee of the type 'PVT_ST' to the patient sale. This will be selected by default if <i>no</i> NHS reason has been defined for this patient on the main form.
Re-test	This is for when a patient has returned for a re-test This will not modify their recall date, nor will it automatically add a fee to the patient sale (though you will be able to add one manually if appropriate, e.g. if the patient has an additional OCT scan.)
Exam elsewhere	This would not usually be selected from this form, but it's the default exam type when a prescription is added to the summary Rx form; no fee is added.

Non sight test	This is for non sight-test examinations, e.g. WEHEs or Scottish supplementaries. The prescription (if any) will not be used in dispensing or used as merge fields in Px docs, no fee will be added automatically and no recall scheme will be added. (If you wish to assign this patient to an additional recall scheme you can do so manually, from the Patient Communication tab on the main patient form.)
Non ST valid Rx	This is for a non sight-test examination, but one where the patient was refracted and so the prescription is valid and can be used for a subsequent dispensing. The other behaviour is as described above.

Recall Scheme

 A screenshot of a web form element labeled 'Recall Scheme'. It is a dropdown menu with '12 months' selected and a downward arrow icon on the right.

This is where you assign this patient to an appropriate recall scheme. The type of scheme that you can choose from is defined in the Recall Schemes tab of Maintenance – this form only displays those schemes of Scheme Type ‘Eye Exam’.

If a patient is already assigned to a recall scheme before this examination, (i.e. they are an existing patient) then this will be the default scheme; you should make sure that this is still appropriate.

Also, note that your system may be configured so that the patient’s ‘Next Due Date’ is automatically reset when the patient arrives for their appointment, rather than at the end of the examination. We advise against this when the clinical records module is being used, because you may change the examination type during the course of the examination, e.g. to a ‘Non sight test’ type, and want to leave the original sight test recall as it was. This can be turned off in Maintenance, Branches tab, ‘Arrival resets recall’ option.

Next Due Date

 A screenshot of a web form element labeled 'Next Due Date'. It is a date picker showing the date '20/08/2020' with a calendar icon and a dropdown arrow on the right.

This defaults to the date of the current exam plus the number of days specified in the Maintenance/Recall Scheme tab for the selected Recall Scheme. This then becomes the date that is displayed on the main patient form, highlighted in pink if the next examination is overdue.

Note that you can overwrite this date with a different date of your choosing; this means that you don’t have to have recall schemes for every possible interval, e.g. instead of having a 3 Month Recall Scheme, 6 Month Recall Scheme, 9 Month Recall scheme etc, you can have a single scheme, e.g. ‘Next Recall < 12 Months’, and amend the Next Due date as appropriate. This can save a significant amount of maintenance, however if you do this you *must* remember to set the Next Recall date correctly from the main patient form/Communication tab, so that the patient receives their first recall before the Next Due date – the two are NOT automatically linked.



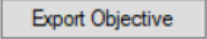

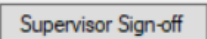
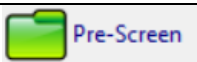
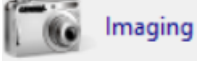
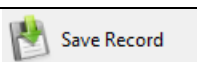

Dispensing Notes



This is where you can record any dispensing/lifestyle factors that you have discussed with your patient. The contents of this field will appear on the Summary Rx form, and also copied through to any new dispensings. The is default tag - <<DispensingNotes>> - which enables you to pre-define possible answers.

Clinical Record – Buttons

Button	Function
Create Document	This allows you to select a predefined template (e.g. a Word document or email template) and create a communication completed with details from the patient record. A copy of each communication generated here will be saved with the patient record.
Store Document	This allows you to save documents with the patient record that haven't been created by i-Clarity, e.g. letters from GPs, responses to referrals, fields etc. The relevant document should first be saved in a folder that is accessible to this PC, then you click this button, select the document, select the folder that you wish to save the document in, and click OK. The list of possible patient folders is specified in Maintenance, Misc 4 tab.
Scan and Store	If you have a compatible scanner this allows you to directly scan the document (single page only) by placing the document on the scanner then clicking this button. This will start the scanning process automatically so you then just need to choose the appropriate patient folder to store it in.
Retrieve Document	This allows you to retrieve and display any patient documents created or stored using the procedures described above.
Load Drawings	This allows you to create, view and edit drawings that are stored with the patient record. These drawings can be based on bitmap templates that are stored in the location specified in the Branch tab of maintenance, 'Drawings Templates path'.
New Clinical Record	Once you have a created a clinical record for a patient, the most recent is displayed. To create a new clinical record you must click this button.
Load Pre-Screening	This allows you to load a previous Pre-Screen record, select the record you want from the
Summary	This button displays all the clinical record notes fields in the form of a report that you can scroll through. You can view this at the same time as you are viewing and editing the current clinical record .
Audit Clinical Record	Although the audit file is created or updated automatically whenever you exit an updated clinical record form, you can use this button to force an update to occur.
Remove All Tags	Once you have completed a clinical record there may still be unused tags that you haven't used because there were not

	<p>necessary on this occasion. This button removes unused tags so that the final record is clearer.</p> <p>Note that this will NOT remove tags that are listed as required for compliance purposes. Also, if you wish to reinstate a tag, then you can press Ctrl + Alt + T to display the full list of tags appropriate for the current field.</p>
 	This allows you to switch between the CL and Other clinical record forms (subject to having appropriate permissions.) These can all be open at the same time.
	This button allows you to export the objective Rx to a suitably configured instrument, e.g. phoropter.
	This allows you to receive data from suitably configured instruments, e.g. lensmeters (which will then populate the Spec History), autorefractors (which can populate pressures, pachymetry and objective Rx), and phoropter (which can populate the subjective.)
	This allows a user to 'sign-off' the clinical record that has been completed by someone else, e.g. a student or pre-reg.
	This allows you to import the 'Reasons for Visit' notes into the Main Reasons for Visit field on the clinical record.
	This allows you to access the i-Clarity Imaging menu, which in turns allows you to take, store and review imaging data from a variety of different systems including fundus cameras, slit lamps and OCTs. (See the discussion of Imaging at the end of this chapter for further details of this.)
	This allows you to save the current record then continue working on it.
	This allows you to quit this Clinical Record.

Finalising the Examination

When you first exit a new Clinical Record, you are presented with the 'Confirm Clinical Record Screen, which looks like this:

Confirm Clinical Record

Clinical Record Date: 04-Oct-2019

Type:

Recommendation:

ST Recall:

Other Recall:

Next Due Date:

Early Recall:

Referred: ☐ Response Received: ☐

Available Fees:

CL Teaching Appointment
Dispensing Fee
DVLA
Edenred Sight Test
EHEW Band 1
EHEW Band 2
EHEW Band 3
Eyecareplan Sight Test
Fields private

Selected Fees:

NHS Sight Test

Note: You do NOT have to complete this when you first exit a record, e.g. you may wish to close a record then return to it to decide an appropriate recall interval, or whether or not to charge additional fees or refer the patient. If this is the case then click the button 'Close Without Confirming Details'. This form will continue to be displayed whenever you access the clinical record until you click either of the two confirm buttons.

Because the information that you need to 'sign off' is so important there is a field on the 'Clinic Outcomes' report – 'Fin'(alised) – which is set to 'Y' once the clinic has been confirmed. We strongly recommend reviewing this report after each clinic to ensure that the record has been fully completed. This way you can check that the relevant patient data has been updated.