Contact Lens Clinical Record

i-Clarity Version 3.3.2

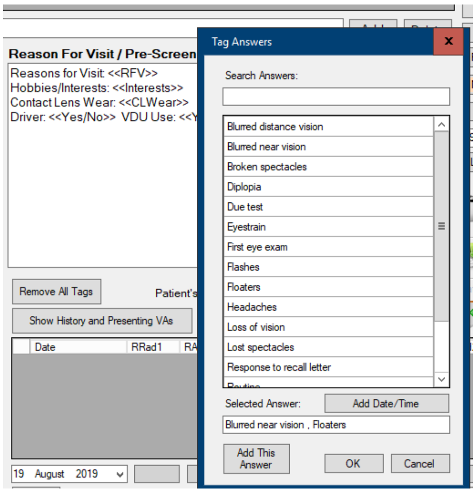
The i-Clarity Clinical Records module consists of 4 record types: Pre-Screening, Clinical Records, CL Records and Non-Sight Test (Other).

Contact Lens Clinical Record

The contact lens clinical record form is intended to record the clinical notes of any exam related to a contact lens appointment.

There are several text fields throughout the form, 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.



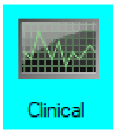
Templates come in two forms, either *Generic* – that is, they are usable by all members of the practice, or *Individual* – they are specific to the currently logged in user.

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, 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 move through the prompts in a template by pressing the Tab key on your keyboard (that will automatically move the insertion point, to the next colon (:)

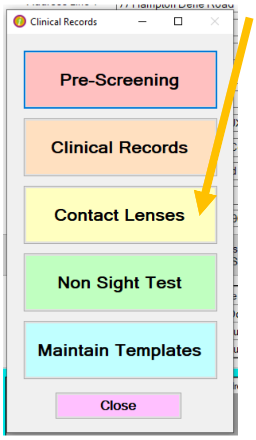
Contact Lens Clinical Record Form Features

To open the Contact Lens Clinical Record form,



Click on the Clinical icon.

This will open the clinical menu.



Click on the Contact Lenses button.

This will open a contact lens clinical form for the active patient.

For patients who have had a contact lens exam before the form will open with the last record visible.

For patients without a previous record a new record will be shown.

The behaviour and use of each of the contact lens clinical record form fields is described below.

Patient Details.

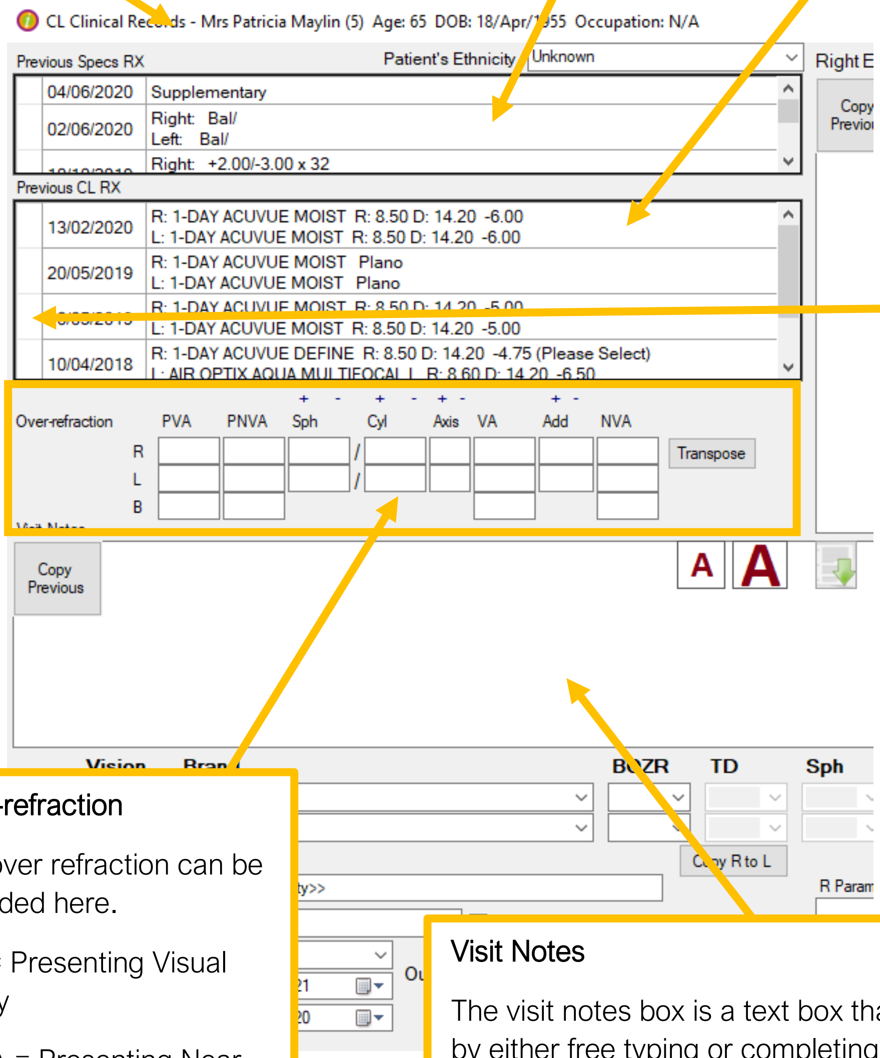
The patient's Name, ID number, Age, DOB and Occupation are show at the top of the form.

Previous Spec Rx

The patient's previous spectacle prescriptions are listed here in descending date order.

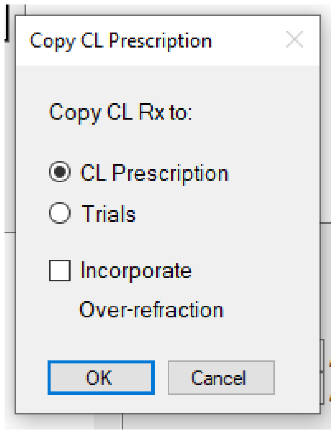
Previous CL Order

The patient's previous contact lens prescriptions are displayed here, in descending date order.



Copying the previous CL RX

Double clicking on the box next to a previous contact lens prescription will give you an option to copy this to the new prescription field or the trial lens form.



Over-refraction

Any over refraction can be recorded here.

PVA= Presenting Visual Acuity

PNVA = Presenting Near Visual Acuity

Visit Notes

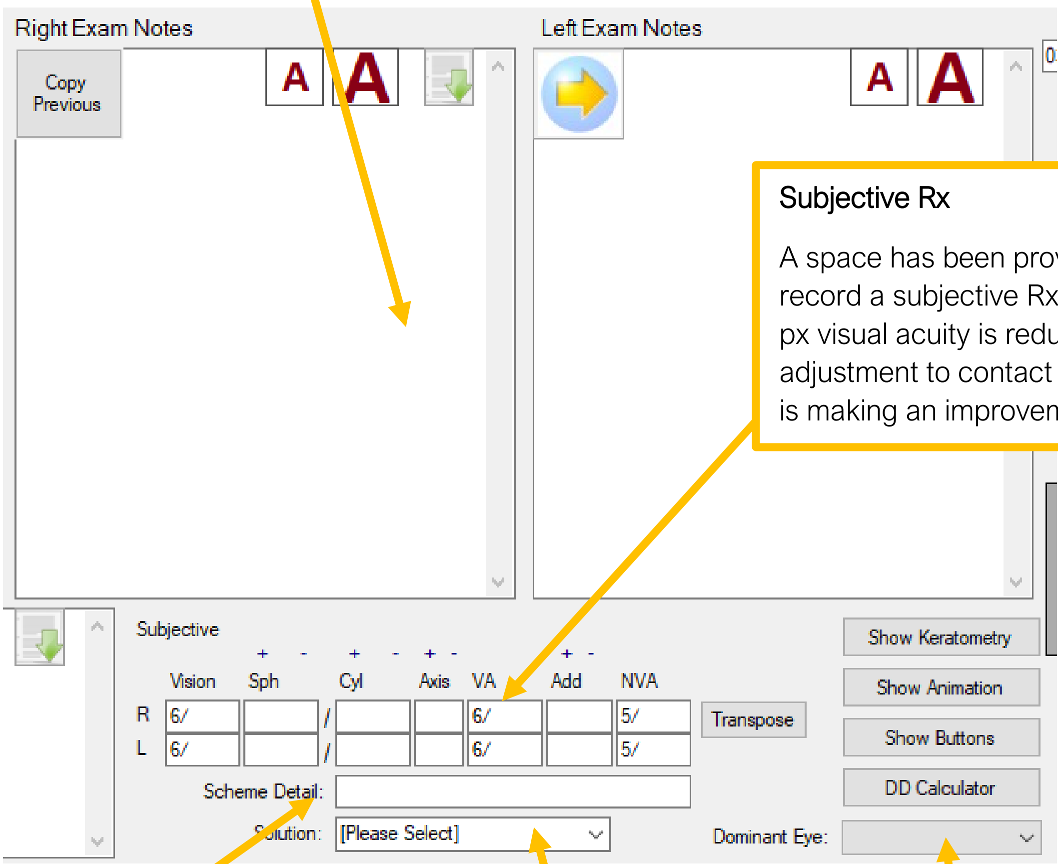
The visit notes box is a text box that can be completed by either free typing or completing a predefined template (or a combination of both methods).

Prompts you would include on this template might be;

- reason for visit – recheck, symptoms
- comfort of current lenses
- wearing time of current lenses

Right Exam Notes and Left Exam Notes

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.



Subjective Rx

A space has been provided for you to record a subjective Rx if needed e.g. px visual acuity is reduced and no adjustment to contact lens prescription is making an improvement.

Scheme Detail

Here you can record details of any automatic shipment/supplier scheme the patient may be on.

Dominant Eye

Dominant Eye can be recorded by selecting from the drop down.

Solution

Here you can select from this list of solutions on your system the solution the patient uses.

CL Prescription

Firstly, select the brand of contact lens from the drop-down list. Once a brand has been selected the first set of validation will be available for selection from the first value drop down list.

Select the validated option for each prescription value moving from left to right.

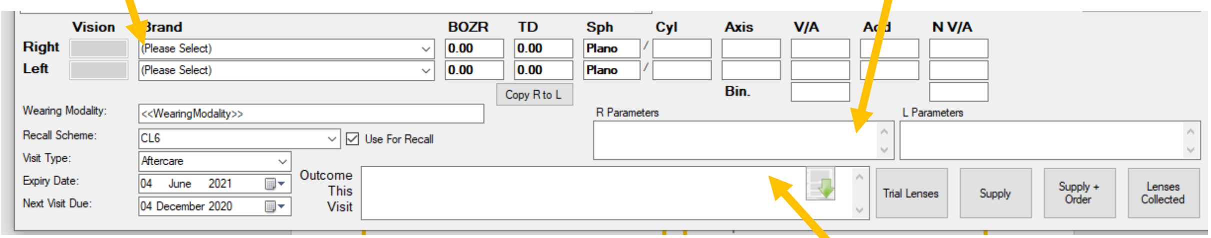
Once you have completed the right eye, you can either complete the left eye in the same way or you can click the 'Copy Right to Left' button. This will copy all the values from the right eye to the left eye and then you can make any necessary edits as required

Parameters

Underneath the prescription is a field for the right and left eye call parameters.

Anything entered in this field will be attached to the Contact Lens prescription and will be shown on contact lens orders in other areas of the system.

This field is useful for RGP lenses.



Wearing Modality

Click on the tag for wearing modality to show the list of linked tag answers.

Recall Scheme

Select from the drop-down list at the top of the form the recall that is applicable to that patient.

Selecting a recall scheme automatically updates the Next Visit Due and Expiry date fields on the prescription.

Visit Type

Select a type option for the type of appointment that was completed.

The options available in the visit type field are; Aftercare, New CL Rx, Update CL Rx, Replacement, Trials Evaluation, Emergency.

Outcome this visit

This is another text field that can be completely blank or can be populated with a template.

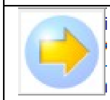
Here you would record any outcome information about the contact lens exam.

The expiry date links to CL Orders. For one off orders, expired CL prescriptions will show a warning before ordering. Recurring orders will stop if the CL Prescription has expired.

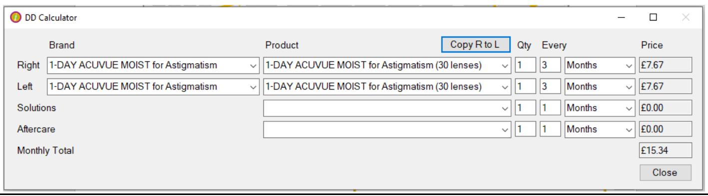
The next due date will be displayed on the patient front screen along with a note of the recall scheme the patient is on. You can amend the next due date by clicking on the calendar icon. This will amend the date on this form and the patient front screen, but it will NOT amend the send date of the recall communication. This must be done in the communications tab of the patient record.

Non- Sight Test Form – Buttons

Button	Function
Create Document	This allows you to select a predefined document (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.
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	When you open the Contact Lens Clinical Form for a patient, if they have had a record created previously it will be displayed. To create a new record, click the 'New Record' Button

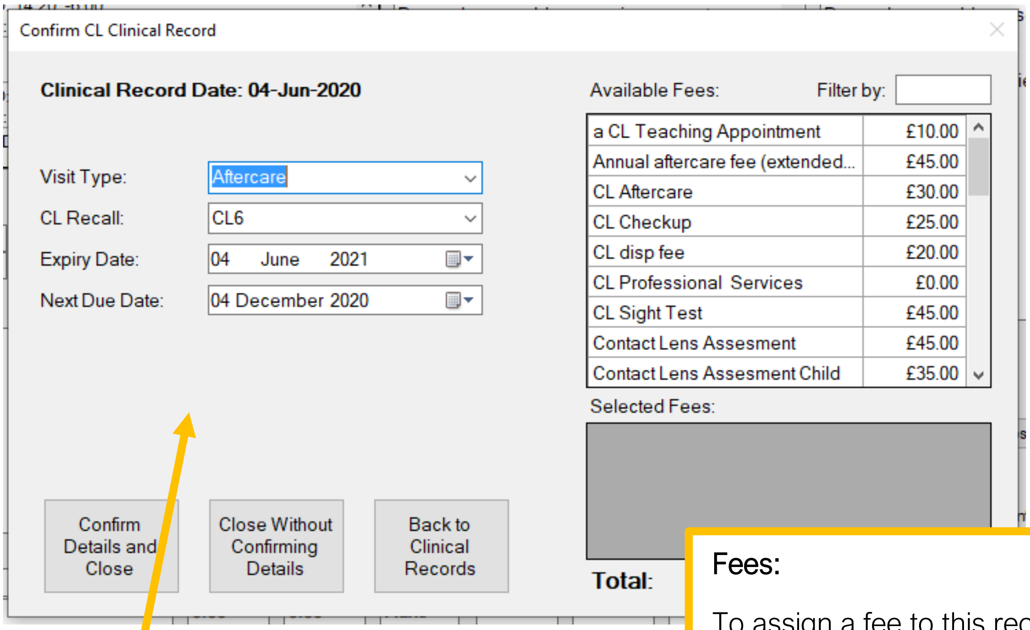
Copy Previous	This allows you to copy the contents of these boxes from the previous record. You can then edit and update the contents. You must do this before you start entering new details as this action will overwrite the contents of all 3 boxes.
	This copies the contents of the Right notes field into the Left notes field – again, take care because this action will *overwrite* the contents of the Left notes field so you should do this before you start amending the contents.
A A	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. *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.*

Rx Other	This allows you to switch between the Rx and Other clinical record forms. These forms can be open at the same time as each other and your current form.
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 necessary on this occasion. This button removes unused tags so that the final record is clearer. 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.
Supervisor Sign-off	This allows a user to 'sign-off' the clinical record that has been completed by someone else, e.g. a student or pre-reg.
Imaging	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.)
Save	This allows you to save the current record then continue working on it.
Exit Clinical	This allows you to quit this Clinical Record.

Show Keratometry	Opens a form to enter k readings.
Show Animation	**Show Animation,** this will open a menu of links to videos. Clicking on a link will open the webpage that video is hosted on. This menu of videos is created in the maintenance module of your i-Clarity system.
Show Buttons	After you start typing in a text field the template and font size button will disappear, clicking this button will make them reappear.
DD Calculator	***DD Calculator****, opens a new window which allows you to calculate how much a patient will pay monthly depending on the prescribed lens brand and the quantity worn over a selected time period.* 

Finalising the Examination

When you first exit a new Record, you are presented with the 'Confirm CL Clinical Record' Screen, which looks like this. This form allows you to double check the visit type and recall selected and then to apply fees to the patient's account.



Fees:

To assign a fee to this record so that it appears on the patient account when you confirm this record, double click on the relevant fee listed in the top box.

If you have selected a fee incorrectly, double click it in the bottom box and it will be removed from the selected fees box and reappear in the available fees list.

Warnings:

Certain fields, when not completed, will cause a warning note to appear on this confirmation form. These include recall and template compliance options.

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 on the confirm button.

Because the information that you need to 'confirm' is so important there is a column on the 'Clinic Outcomes' report – 'Fin'(Finalised) – which is set to 'Y' once the record has been confirmed. We strongly recommend reviewing this report after each clinic to ensure that each record has been fully completed. This way you can check that each record from the day's clinic has been updated.