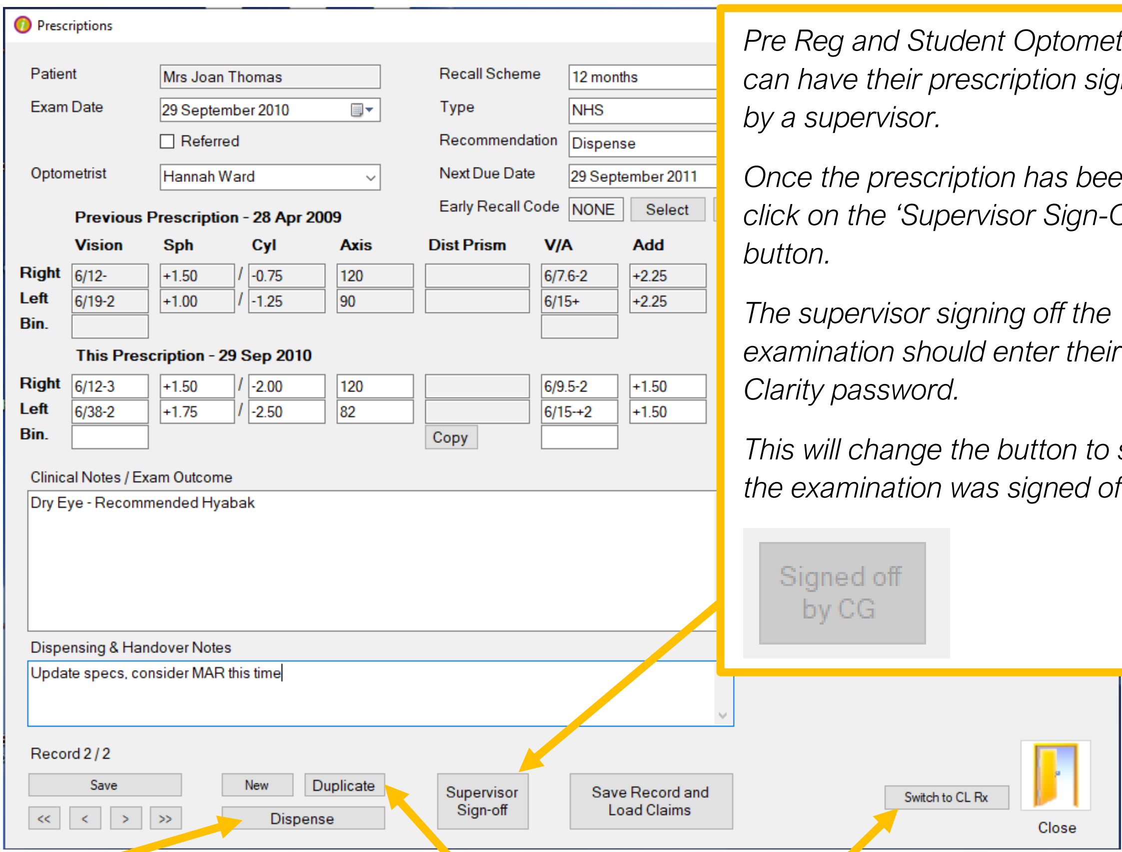
Entering a spectacle prescription

i-Clarity Version 3.3.2

If you are not using the i-Clarity clinical records, then prescriptions for a patient are entered in the Rx area. If you are using clinical records, then a summary prescription will be automatically created in this form so that it can be viewed by the front of house team. You would also use this form to enter prescriptions from elsewhere.

Features of the Patient Prescription Form



Pre Reg and Student Optometrists can have their prescription signed off by a supervisor.

Once the prescription has been saved click on the 'Supervisor Sign-Off' button.

The supervisor signing off the examination should enter their i-Clarity password.

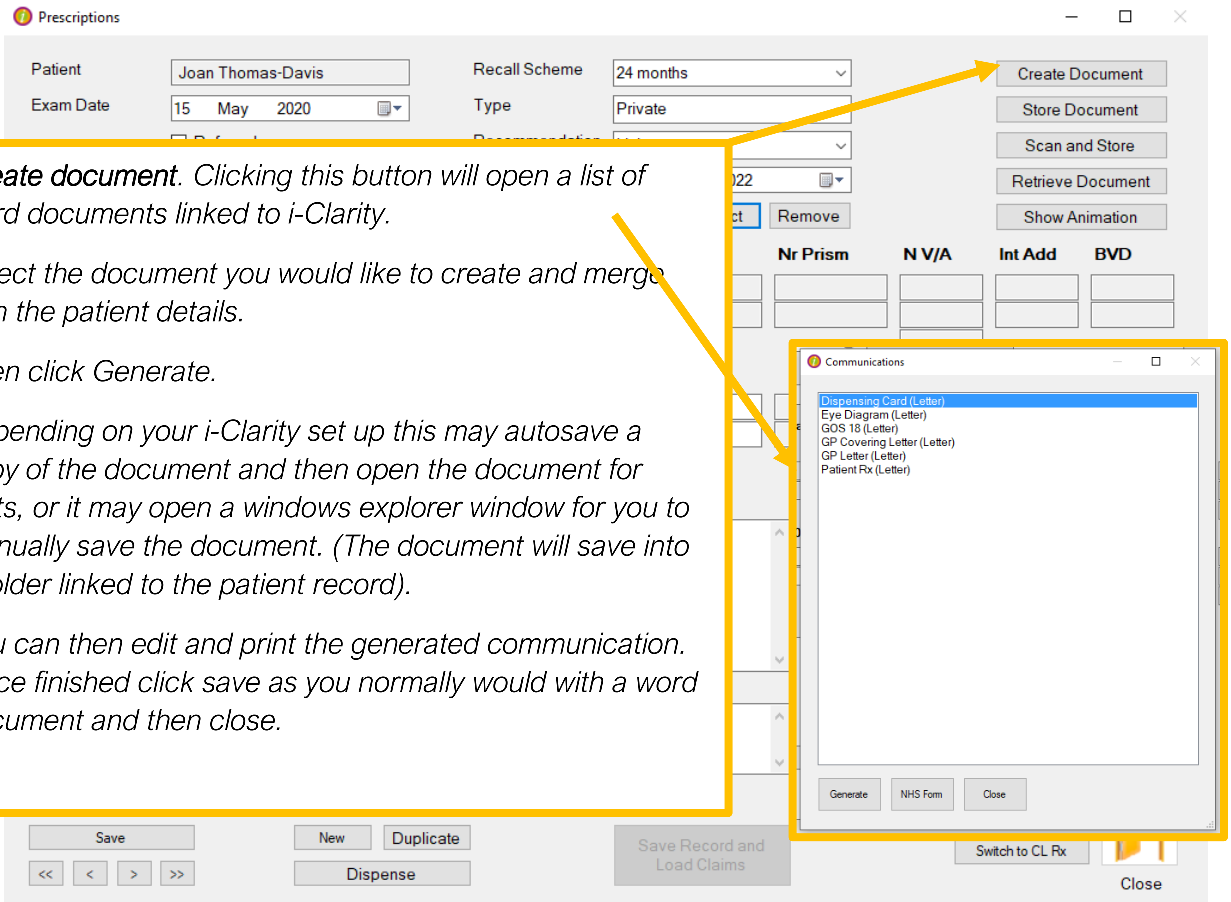
This will change the button to say who the examination was signed off by.

Signed off by CG

Dispense, Opens the dispense module and pulls through the prescription linked to the open form. Navigating back to an older prescription before clicking the dispense button will allow you to dispense an old prescription.

Creates a copy of the selected prescription including fields at the top of the form.

Switches your i-Clarity from the spectacle prescription form to the CL prescription form.


Prescriptions
Patient
Joan Thomas-Davis
Exam Date
15 May 2020
Recall Scheme
24 months
Type
Private
Create Document
Store Document
Scan and Store
Retrieve Document
Show Animation
Remove
Nr Prism
N V/A
Int Add
BVD
Create document. Clicking this button will open a list of word documents linked to i-Clarity.
Select the document you would like to create and merge with the patient details.
Then click Generate.
Depending on your i-Clarity set up this may autosave a copy of the document and then open the document for edits, or it may open a windows explorer window for you to manually save the document. (The document will save into a folder linked to the patient record).
You can then edit and print the generated communication. Once finished click save as you normally would with a word document and then close.
Communications
Dispensing Card (Letter)
Eye Diagram (Letter)
GOS 18 (Letter)
GP Covering Letter (Letter)
GP Letter (Letter)
Patient Rx (Letter)
Generate
NHS Form
Close
Save
New
Duplicate
Dispense
Save Record and Load Claims
Switch to CL Rx
Close

Store document allows you to save a document on your computer to the patient folder.

Click store document.

This will open a windows explorer window.

Navigate to your file.

Select the file.

Click Open.

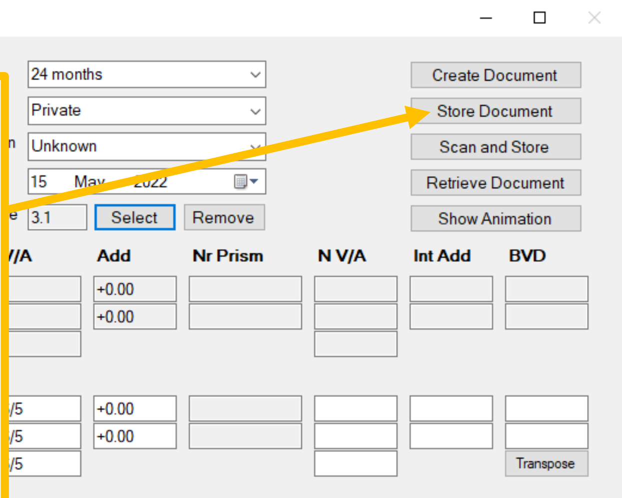
This will open a store file window.

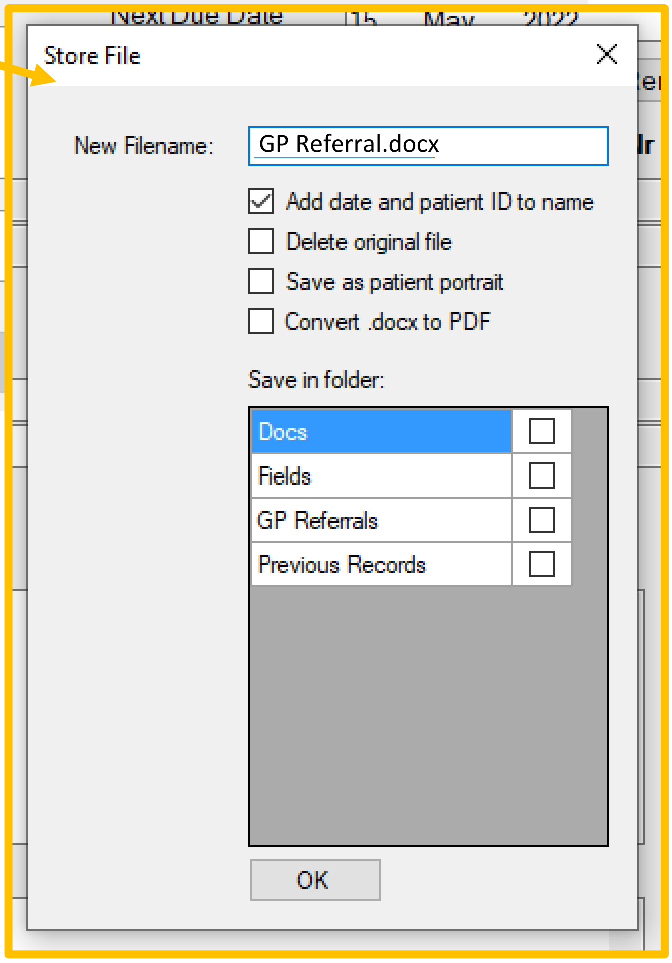
If required, you can edit the name of the file at the top before it saves to the patient record.

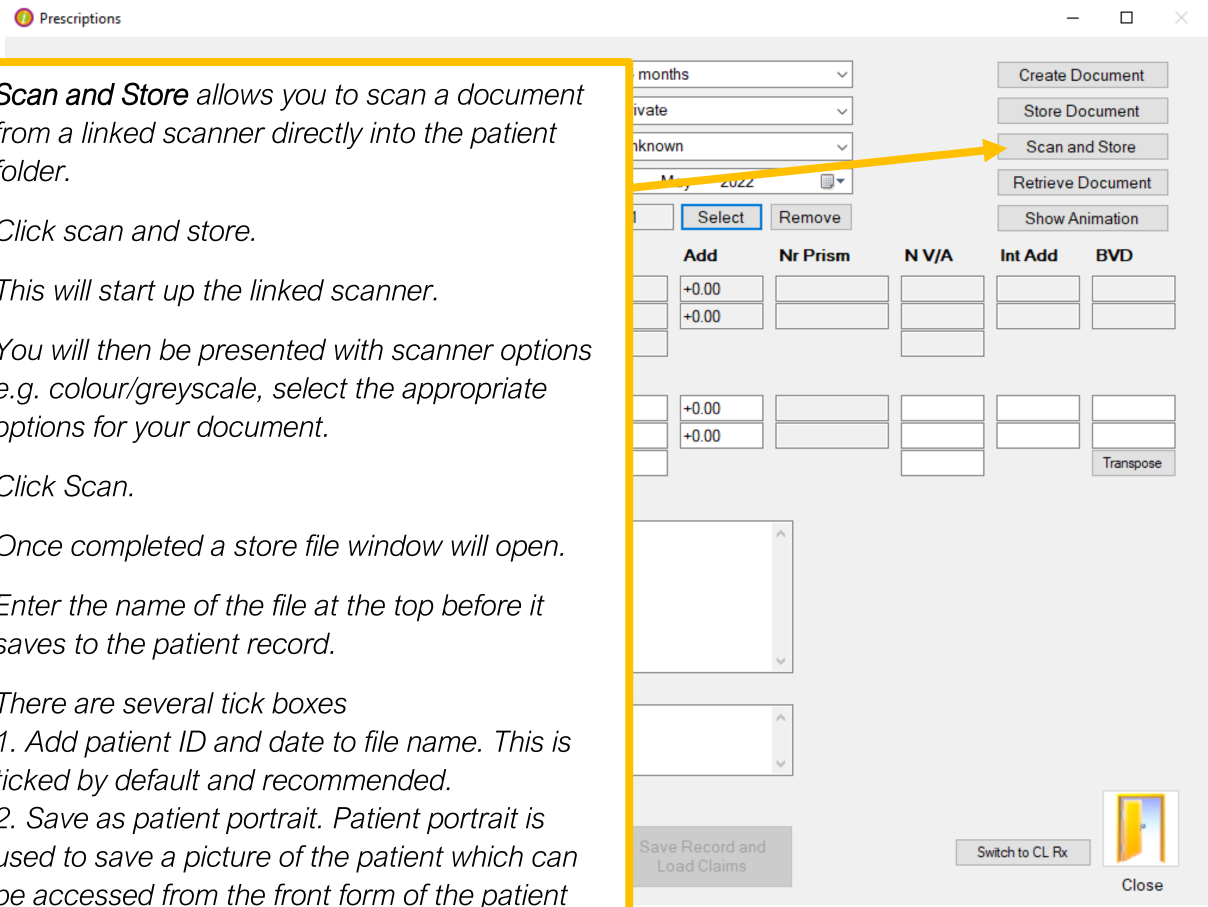
There are four tick boxes
1. Add patient ID and date to file name. This is ticked by default and recommended.
2. Delete original file. Ticking this will delete the original file so you do not have to store two copies or manually go back and delete the original off your computer.
3. Save as patient portrait. Patient portrait is used to save a picture of the patient which can be accessed from the front form of the patient record.
4. Convert docx to PDF. Will convert a word document to a pdf on saving.

Underneath is a box which lists the folders within the patient file that the document could be saved in. This help organise the patient documents. If there is an appropriate folder for the file you are saving tick the box next to the folder name.

Then click OK.







Scan and Store allows you to scan a document from a linked scanner directly into the patient folder.

Click scan and store.

This will start up the linked scanner.

You will then be presented with scanner options e.g. colour/greyscale, select the appropriate options for your document.

Click Scan.

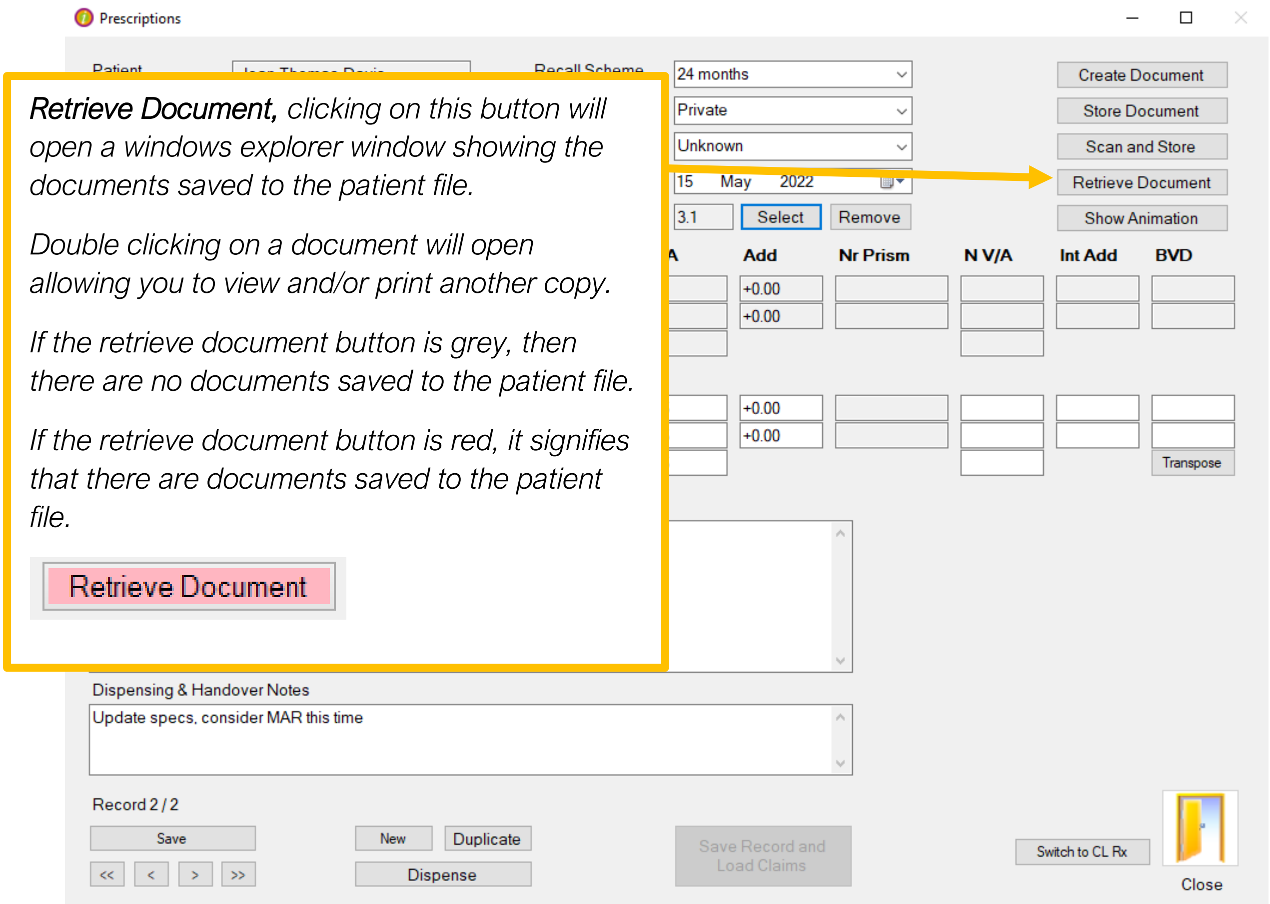
Once completed a store file window will open.

Enter the name of the file at the top before it saves to the patient record.

There are several tick boxes
1. Add patient ID and date to file name. This is ticked by default and recommended.
2. Save as patient portrait. Patient portrait is used to save a picture of the patient which can be accessed from the front form of the patient record.
4. Convert docx to PDF. Will convert a word document to a pdf on saving.

Underneath is a box which lists the folders within the patient file that the document could be saved in. This help organise patient documents. If there is an appropriate folder for the file you are saving tick the box next to the folder name.

Then click OK.



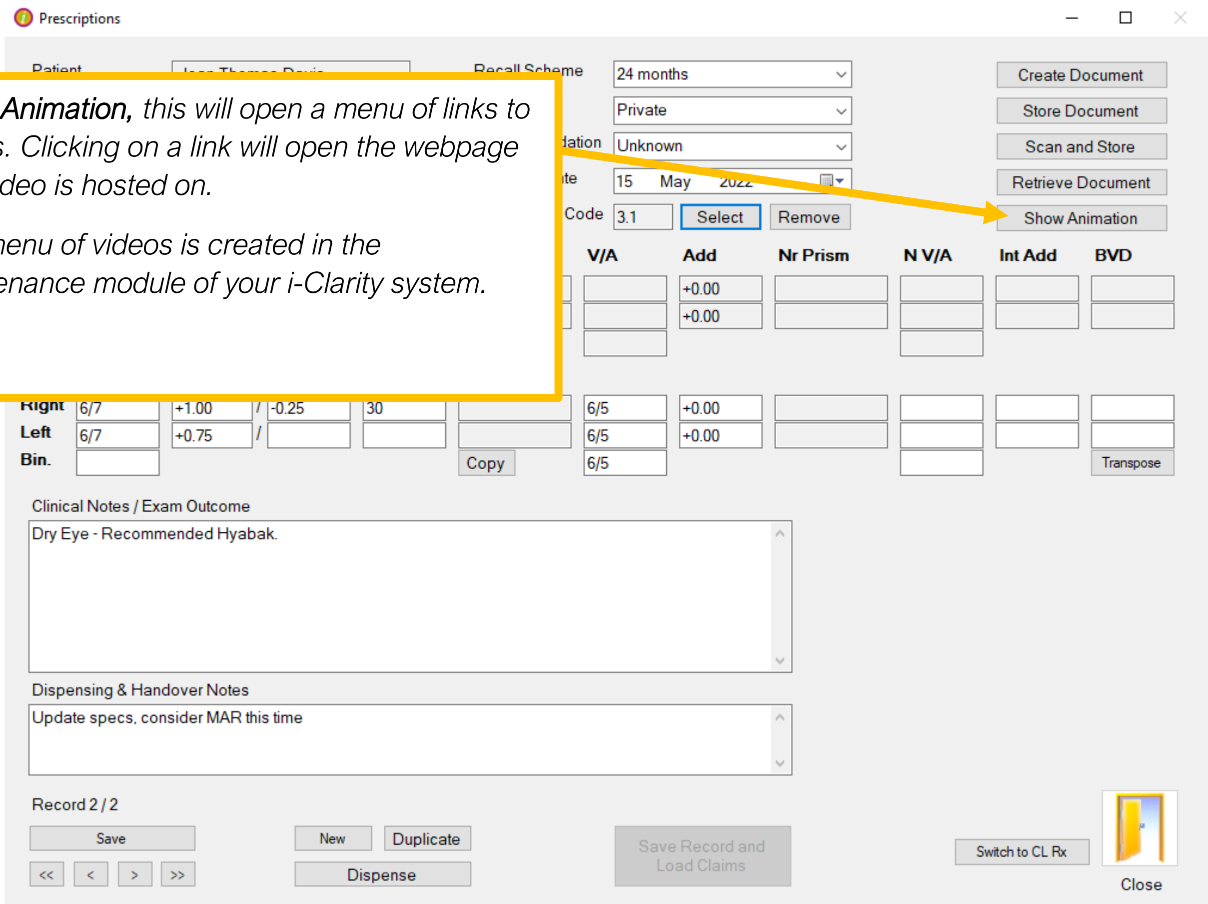
Retrieve Document, clicking on this button will open a windows explorer window showing the documents saved to the patient file.

Double clicking on a document will open allowing you to view and/or print another copy.

If the retrieve document button is grey, then there are no documents saved to the patient file.

If the retrieve document button is red, it signifies that there are documents saved to the patient file.

Retrieve Document

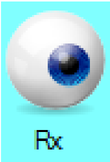


Show Animation, *this will open a menu of links to videos. Clicking on a link will open the webpage that video is hosted on.*

This menu of videos is created in the maintenance module of your i-Clarity system.

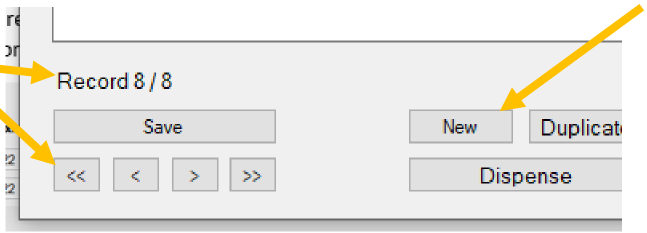
Entering a New Prescription

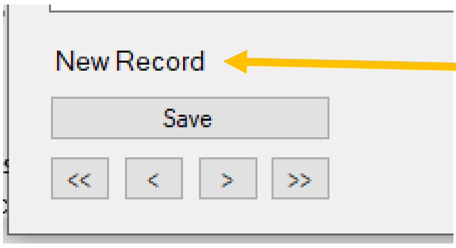
Click on the Rx button



You will be presented with the summary Rx form. If this is the first time that a prescription has been entered for this patient, you will be presented with a new, blank form; if the patient already has a prescription then you must click the New button to create a new Rx form.

If the customer has had prescriptions before it will display how many and you can toggle through each one using the navigation buttons.



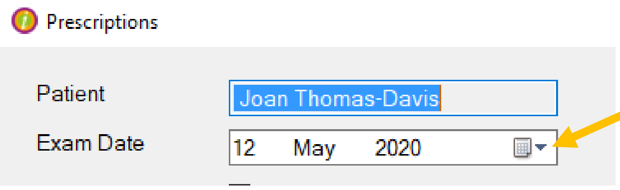


If the customer has not had a prescription entered before it will say New Record. (The number of prescription records will be replaced with the text 'New Record' when you click the new button and will remain until the prescription has been

After clicking the new button, the new prescription form needs to be completed.

The patient's name will be automatically shown at the top of the form.

It will also automatically populate the test date with today's date.

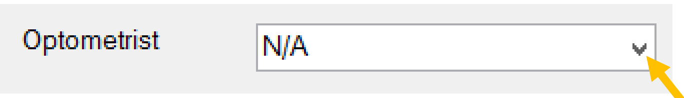


If you are entering a prescription from elsewhere you can click on the calendar icon next to the date and select the test date from the prescription brought in by the patient.

Tick the Referred box if you are referring the patient to another health professional.

The Use For Recall box will be automatically ticked, untick this box if you do not want the new information you are adding to effect the current recall the patient is on. For example, if you are entering a retest prescription.

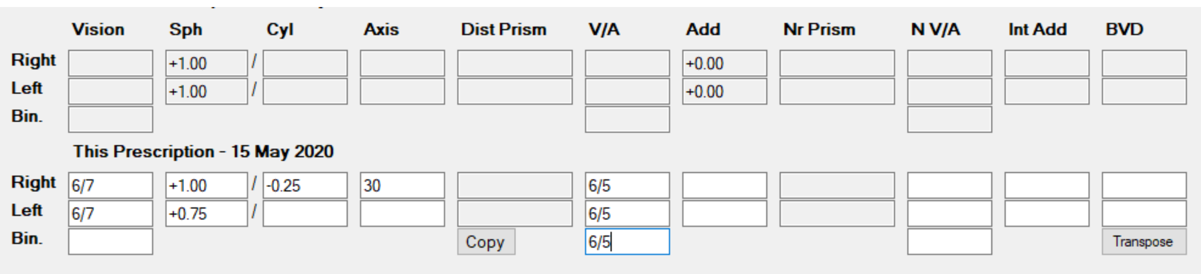
If you are an Optometrist completing a new prescription, then the Optometrist field will be automatically populated with your name.

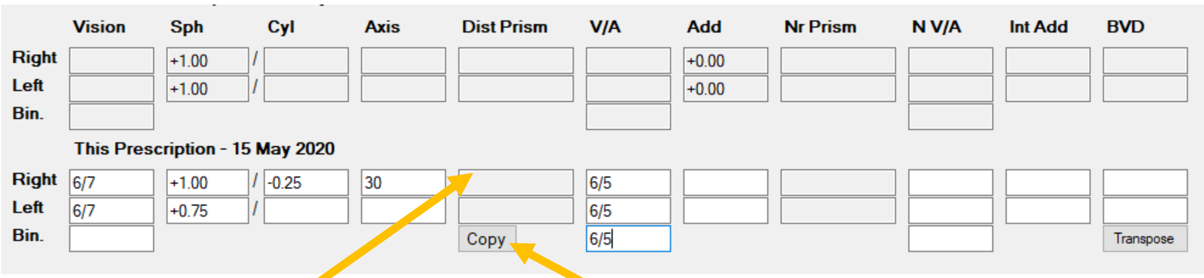


If you are completing a new prescription on behalf of an Optometrist, then you will need to click on the arrow next to the N/A selection and then select the correct Optometrist name from the drop-down list.

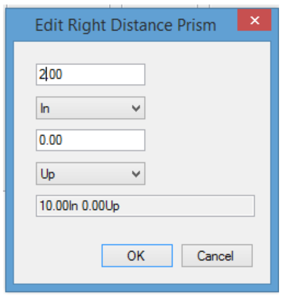
If you are entering an outside Rx then you should leave the Optometrist selection as N/A.

You can then fill out the prescription values, if this is not the first prescription for the patient then you will be able to compare the prescription values against the previous prescription values which are displayed above.



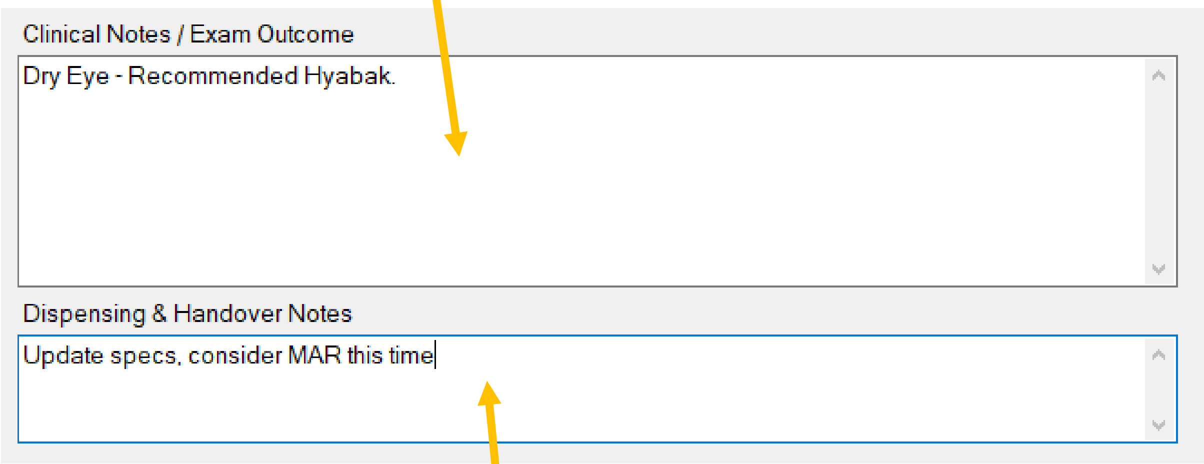


To edit the Prism Values, double click in the field and enter the values in the pop-up box. (This is the same process for Near Prism)



The Copy button under the distance prism values will copy the distance prism values and enter them in the near prism values field.

Next complete any clinical notes about the current prescription/visit that may be of value to anyone viewing the computer prescription without the full paper clinical record. For example, Dry eye drops recommended.



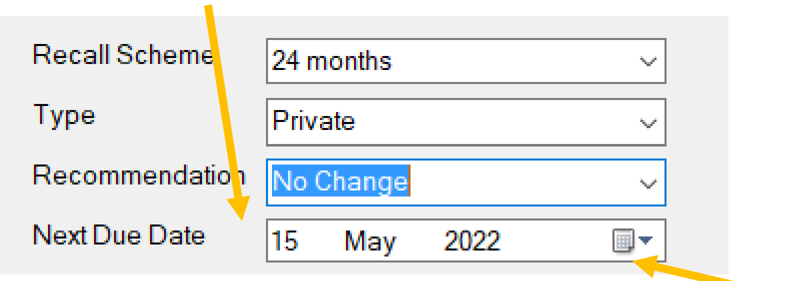
Note anything discussed about new or updating spectacles in the handover notes section.

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

The recall scheme can be left as N/A if the prescription is from elsewhere or it is a visit that does not require a recall e.g. recheck.

For patients who already have a prescription on the system then the recall scheme will automatically be completed with the recall scheme that was selected at the last exam and will only need to be amended if needed.

Selecting a Recall Scheme will automatically populate the Next Due Date.



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.

The type field will be automatically complete with either of the following 3 options;

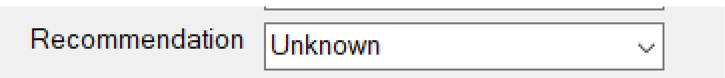
Exam elsewhere – This is the default if you have the full clinical records module, because you should only be adding an outside Rx via this method, all prescriptions created in the practice should be entered in the clinical records module.

Private – This will be the default if the patient does not have an NHS reason selected on the front of their record.

NHS – This will be the default if the patient does have an NHS reason selected on the front of their record.

If the automatic default is not correct, then it can be amended by clicking on the arrow to show the drop-down list of other available options.

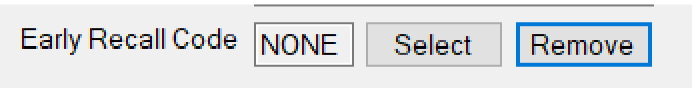
Then you can select a recommendation.



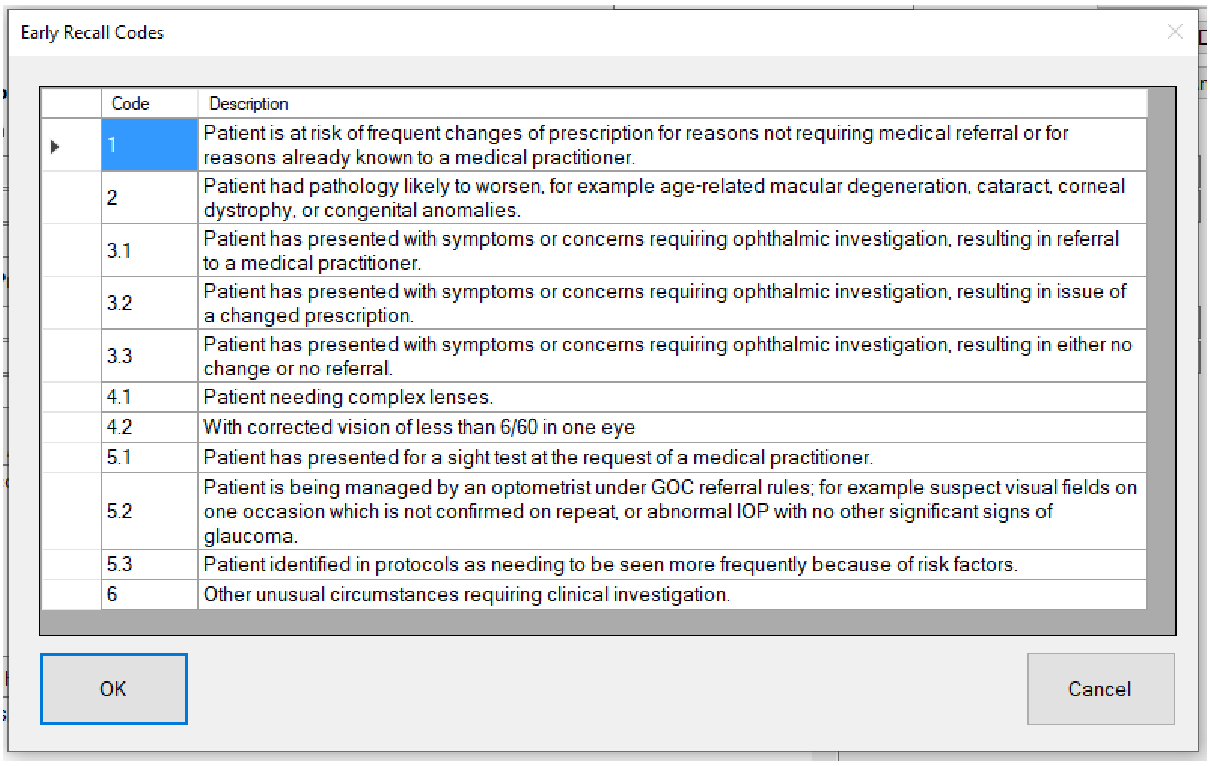
The available options for recommendation are:

Calling Back, CL Dispense, Dispense, Gone Elsewhere, Stable Rx, No Rx, Unknown, No Change.

If needed you can also record an early recall code against a prescription. Click on the select button next to the early recall code field.



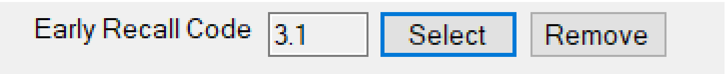
This will open another window that lists all the available codes. Click on the correct code and then click ok.


Early Recall Codes

Code	Description
1	Patient is at risk of frequent changes of prescription for reasons not requiring medical referral or for reasons already known to a medical practitioner.
2	Patient had pathology likely to worsen, for example age-related macular degeneration, cataract, corneal dystrophy, or congenital anomalies.
3.1	Patient has presented with symptoms or concerns requiring ophthalmic investigation, resulting in referral to a medical practitioner.
3.2	Patient has presented with symptoms or concerns requiring ophthalmic investigation, resulting in issue of a changed prescription.
3.3	Patient has presented with symptoms or concerns requiring ophthalmic investigation, resulting in either no change or no referral.
4.1	Patient needing complex lenses.
4.2	With corrected vision of less than 6/60 in one eye
5.1	Patient has presented for a sight test at the request of a medical practitioner.
5.2	Patient is being managed by an optometrist under GOC referral rules; for example suspect visual fields on one occasion which is not confirmed on repeat, or abnormal IOP with no other significant signs of glaucoma.
5.3	Patient identified in protocols as needing to be seen more frequently because of risk factors.
6	Other unusual circumstances requiring clinical investigation.

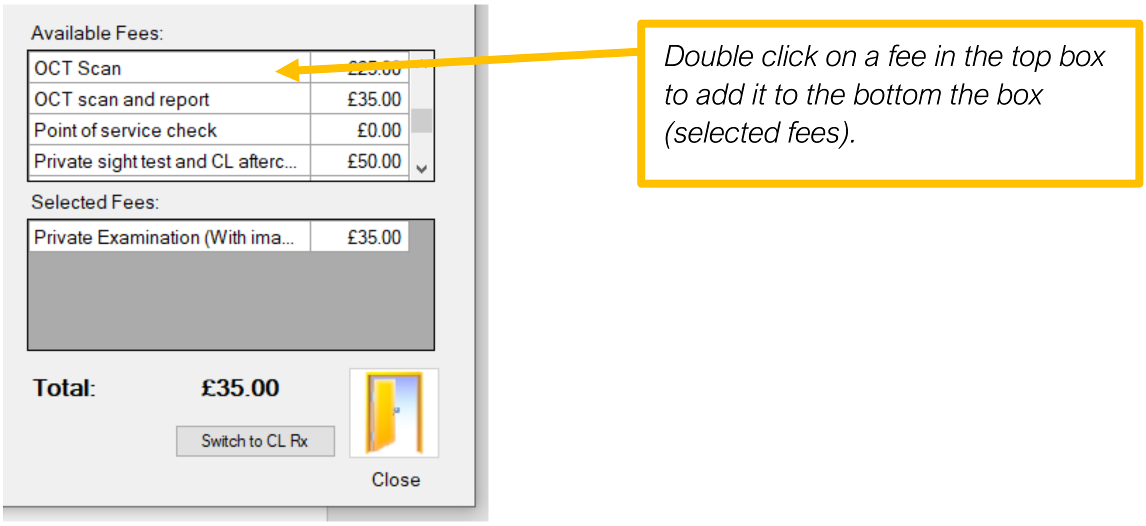
OK Cancel

This will insert the selected early recall code into the field.

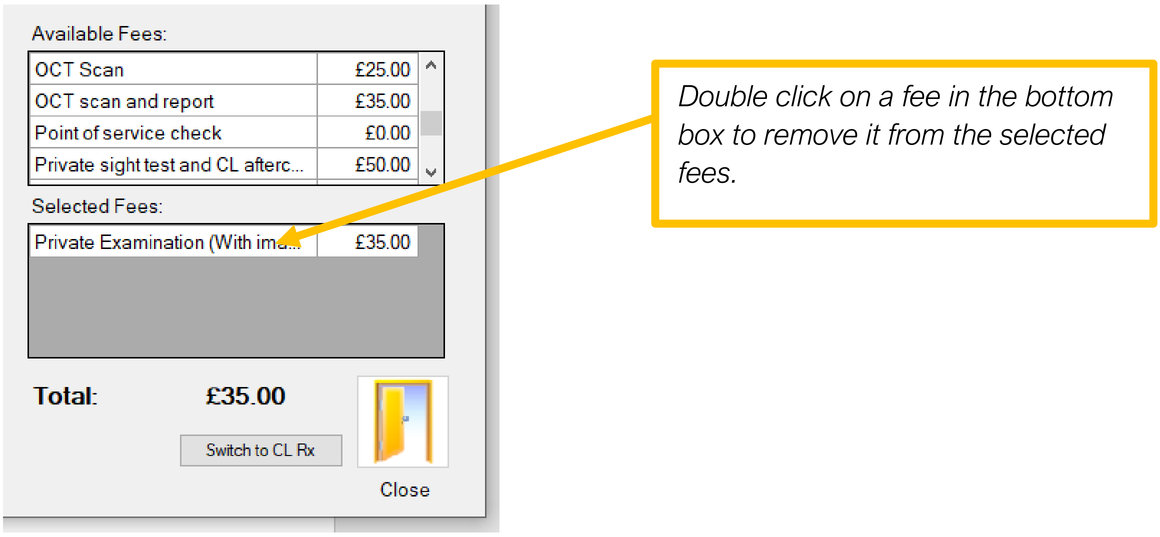


In the bottom right-hand corner of the prescription form is the prescription charges selection box. If the patient has an NHS, or Private exam type selected in the exam type box at the top of the screen then i-Clarity will automatically populate the selected fees box with an NHS sight test fee or a private sight test fee. You can add or amend selected fees, as necessary.

To add an additional fee, double click on the fee listed in the available fees box.



Double click on a selected fee to remove it from the selected fee box.



Any fees in the selected box when the prescription is saved will be automatically put through the patient point of sale account. *Only for advance or pro systems.

Now you are ready to save the prescription for the patient by clicking on the save button.

Once saved, the patient account will be updated with any fees and the front of the patient record will be updated with details of this visit.