Non-Sight Test 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).

Non – Sight Test

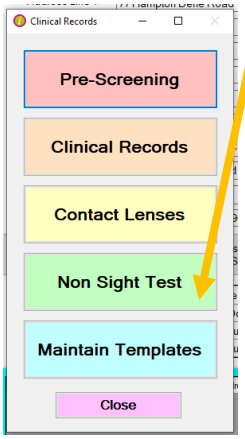
The Non-sight test form is intended to record the clinical notes of any exam that does not require a refraction. For example, it can be used for Dry Eye Assessments, Red Eye Emergencies etc.

Non – Sight Test Form Features

To open the Non- Sight test form

click on the Clinical icon.

This will open the clinical menu.



Click on the Non- Sight test button.

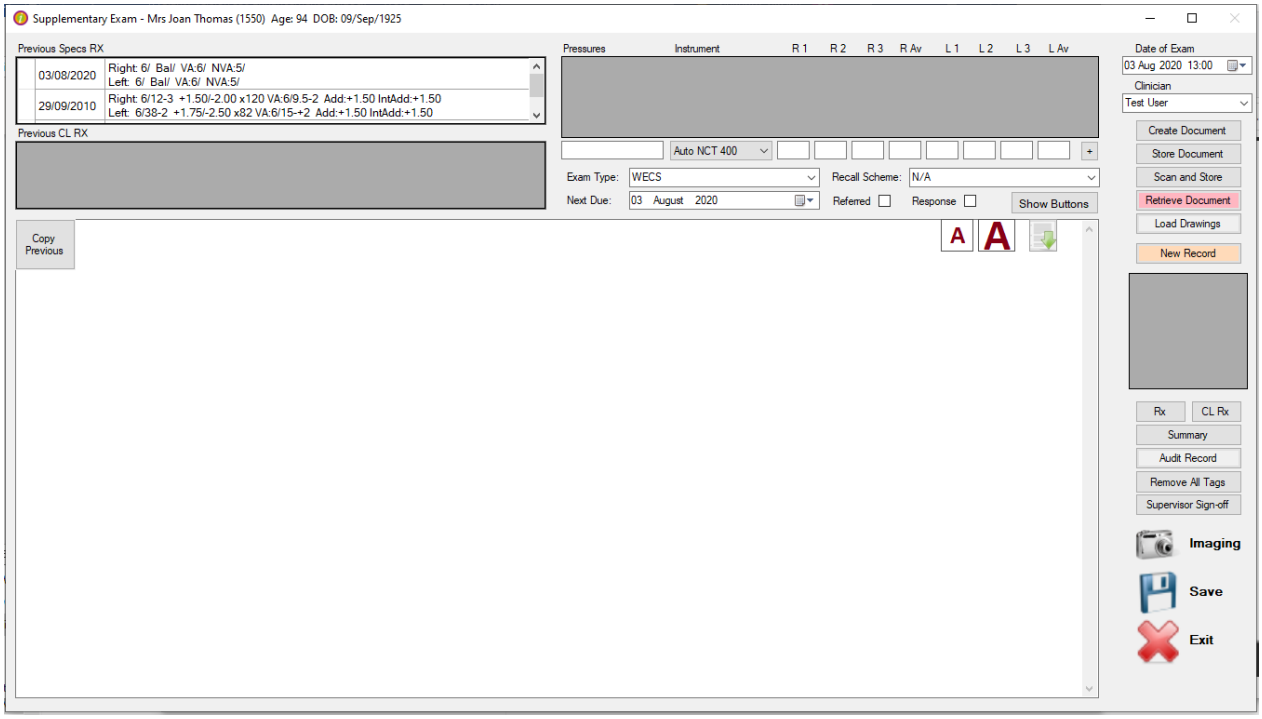
This will open the non-sight test form for the active patient.

For patients who have had a non-sight test exam before the form will open with the last record visible.

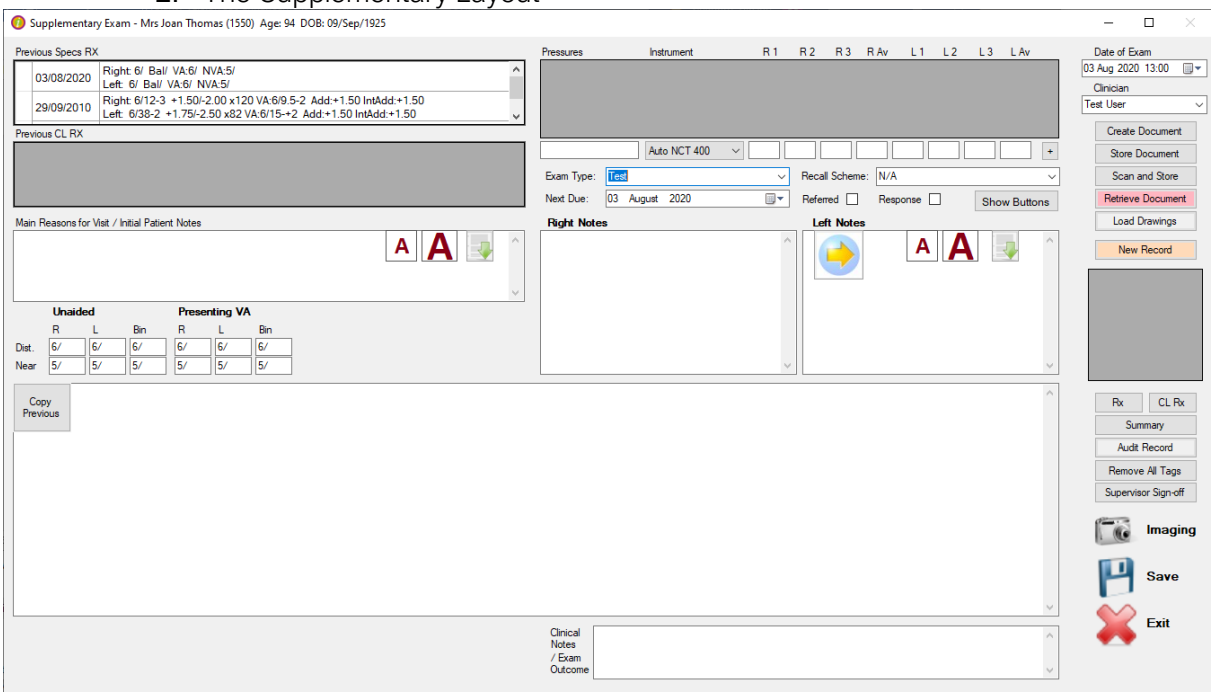
For patients without a previous non-sight test record a new record will be shownwith the default exam type selected.

The Non-Sight Test form has two possible layouts.

1. The standard layout



2. The Supplementary Layout



The behaviour and use of each of the possible non-sight test form fields is described below.

Previous Spec Rx.

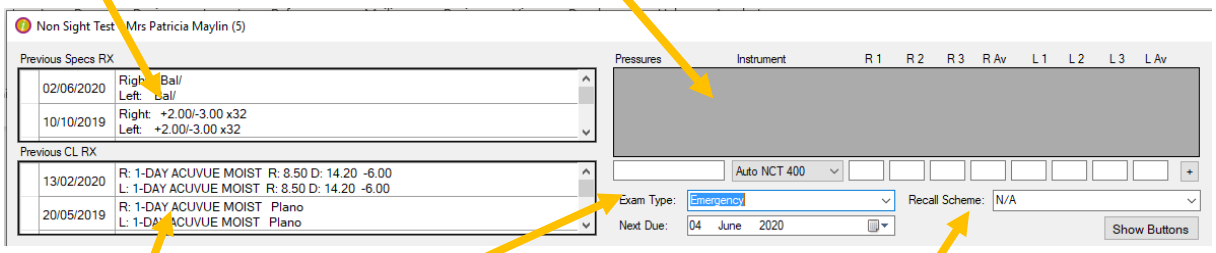
The patient's previous prescriptions are displayed here, in descending order of date.

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).

You can select the instrument from the instrument dropdown.

You can then type in the R and L *average* values and click the Add button (the plus sign).



Previous CL Rx.

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

Exam Type.

This is where you select the type of exam you are conducting.

The exam type set up in maintenance will dictate which layout you see after selection – standard or supplementary.

Recall Scheme

If applicable, this is where you assign this patient to an appropriate recall scheme.

Assigning a recall scheme will update the Next Due date.

You can amend the next due date manually if required.

Main Reason for Visit / Initial Patient 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'.

Here you record the reason the patient is attending the appointment and any answers to your initial questions e.g. symptoms.

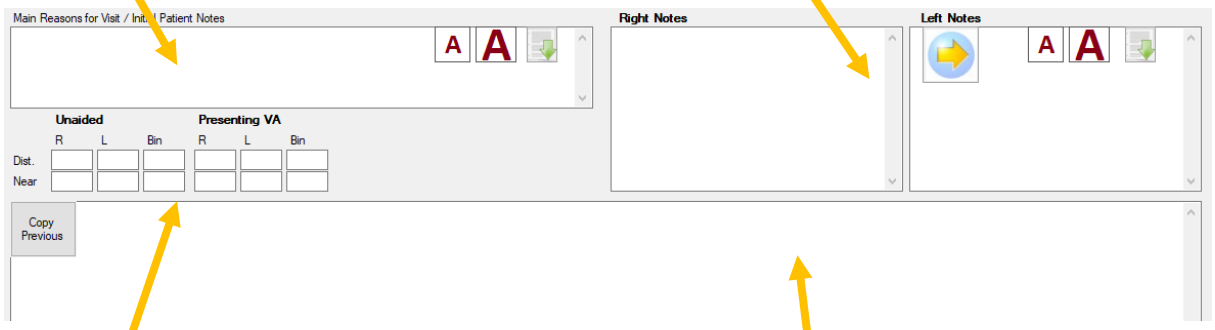
(This notes field is not available on the standard layout)

Right/Left Notes

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

Here you would record any information about the right or left eye examination.

(These notes fields are not available on the standard layout)



Unaided/Presenting VA

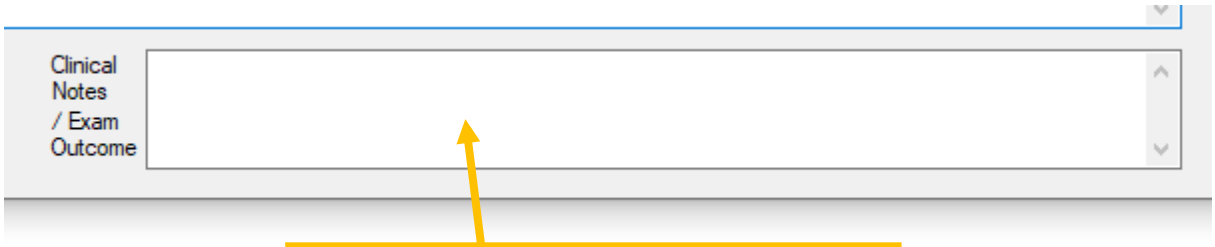
This where you record what the patient can see without and with their current spectacles.

General Notes

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

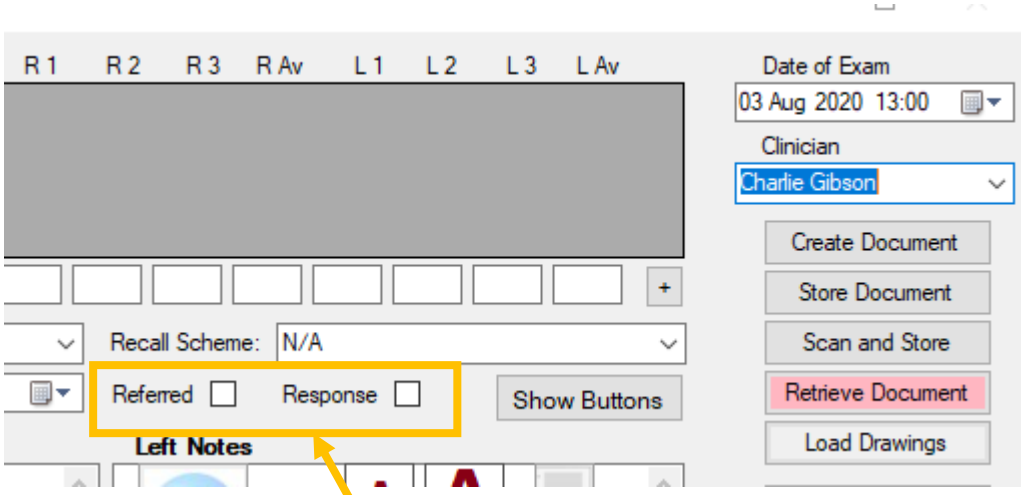
Here you would record any information about the examination.

(This notes field is available on the standard and supplementary layout)



Clinical Notes/Exam Outcome

This is a blank text field that you can type any exam outcome notes in



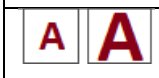
If you are referring the patient tick the referred box. On confirming the clinical record this will create an action point on the patient record assigned to your user login.

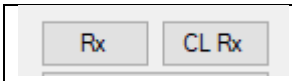
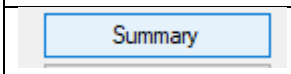
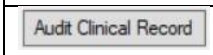
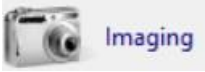
Action Date	Created	Action	Remind	Assigned To	Con
28/Jul/2020	28/Jul/2020	Create referral/report	☑	Charlie Gibson	

You can then use the action list to double check you have completed all patient referrals for that day.

Non- Sight Test Form – Buttons

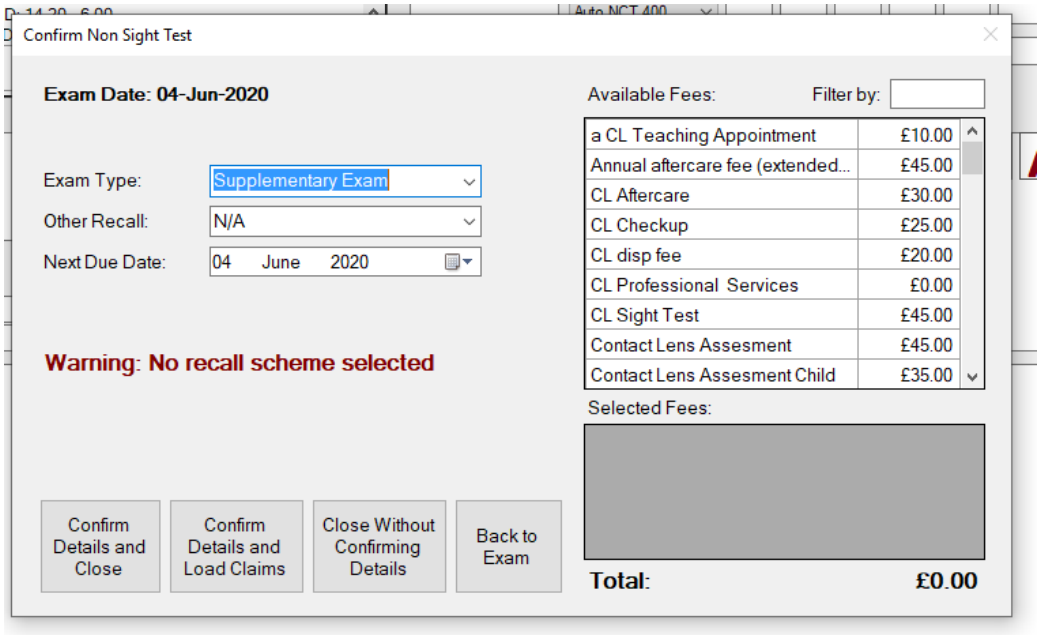
Button	Function
Create Document	This allows you to select a predefined template (e.g. a Word document or email template) and create a communication completed with details from the patient record. A copy of each communication generated here will be saved with the patient record.
Store Document	This allows you to save documents with the patient record that have not 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, then 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 Record	When you open the Non- Sight Test 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 the box 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.
	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.*

	This allows you to switch between the Rx and CL Rx clinical record forms. These forms can be open at the same time as each other and your current form.
	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.
	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.
	Once you have completed a clinical record there may still be unused tags that you have not used because they 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.
	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 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 Record, you are presented with the 'Confirm Non-Sight Test' Screen, which looks like this:



Other recall:

If you did not select a recall on the main form, but a recall is required you can select it on this form.

Warnings:

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

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.

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 '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 the record has been fully completed. This way you can check that each record from the day's clinic has been updated.