Brien Holden Vision Institute

RECORD KEEPING AND REFERRAL LETTERS

THINK

It is impossible to remember all the details of every person that you examine. Even if you could, you need to make sure that, when somebody else examines that person in future, they will know exactly what tests you performed and what results you obtained.

AIM

This unit will teach you how to keep a record of the person's eye examination and how to write a referral letter for a person.

LEARNING OUTCOMES

When you have worked through this unit you should be able to:

- keep patient records which are meaningful to you and other eye care providers
- write a referral letter.

EXAMINATION RECORD

An examination record (or simply a record) is a permanent copy of what was found during a person's eye examination.

Each time a person is examined their record is added to and updated.

Anyone who looks at a person's record should be able to know what the person's problems were and what was done about them. When the person has their eyes examined again in the future, the examiner will know if the person's eyes are getting better or worse.

It is important that the information that is written on the record is written neatly and can be easily understood. Most people use special record cards or record log-books that include information about all the people who have had their eyes examined.

A person's record card contains private information. Most people do not want other people to know about their health or eye problems.

You must make sure that the information that you write on the record card is kept confidential (secret).

DETAILS TO RECORD

PERSONAL DETAILS	• Date of examination • Full name of person • Date of birth (DOB) or age of person • Gender (male or female) • Contact details (address, telephone number, email) • Location of examination (name of clinic/hospital, place of outreach camp)
CASE HISTORY	• Chief complaint and other symptoms • Vision and eye health history (including previous spectacles and visual needs) • General health, medication, allergies • Family history (eye and general health)
VISUAL ACUITY (VA)	• Presenting distance and near VA • Pinhole VA (if necessary) • Unaided, aided, and best corrected VA (for both distance and near)
EXAMINATION RESULTS	• Details and results of all tests performed during the eye examination • Refraction results and spectacle prescription provided • Eye health assessment • Anything else that you notice during the eye examination that you think might be important
DIAGNOSIS AND PLAN	• Identification (name) of the problem(s) • Treatment: spectacles (or medication) prescribed • Referral (if necessary) • Details of what to review or test at the next eye examination
ADVICE	• What you told the person • Explanation of the chief complaint and symptoms • Treatment: what (spectacles or medication) and how to use • Referral: why and what to expect (if necessary) • When to return for their next eye examination • What the person agreed to

DETAILS TO RECORD (cont.)

You must write everything in the person's examination record.

Even if you do a test and the result is normal, or you look at the eye and it is healthy, you must document your findings:

Examples:

"Distance VA (unaided) RE 6/6 LE 6/6"
"No family history of diabetes"
"Cornea clear and healthy"

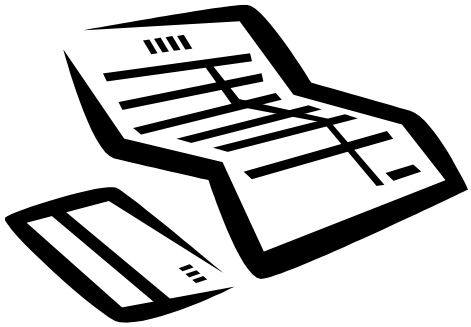
If you do not write your results down, it will be assumed that you did not ask the question or that you did not do the test.

If a result is not written on the record it is the same as if you have not done the test!

EXAMINATION RECORD

RECORD CARD

A record card is a piece of paper or cardboard that can be kept in a folder with the person's other record cards (from previous eye examinations). Record cards can be filed by the person's name or by a number so that they can be found easily in the future.



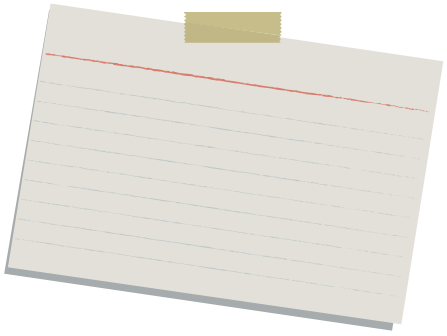


Figure 22.1: *Record cards can be specially printed (or photocopied) so that the layout of all the cards is identical, or they can be blank so that you can write whatever you like*

EXAMPLE: RECORD CARD LAYOUT

Name:		Address:		☐ Male / ☐ Female		Date:			
DOB / Age		Occupation / tasks:							
Chief complaint:									
Case history:									
General health:				Family history:					
Presenting Distance VA aided/unaided				Presenting Near VA aided/unaided					
Distance VA (Unaided)	Distance VA (Aided)	Distance VA (pinhole)		Near VA (Unaided)		Near VA (Aided)			
Eye Health									
PD	Preferred Reading Distance	Other tests							

	Right Eye				Left Eye				Both eyes	
	sph	cyl	axis	VA	sph	cyl	axis	VA	add	VA
Refraction										
Distance prescription given										
Near prescription given										

Diagnosis / treatment / spectacles	
Instructions / Advice given to patient	
Referral to	Examiner

EXAMINATION RECORD (cont.)

RECORD LOG BOOK

A record log-book is sometimes called a line-listing record. It is usually a large book that has the details of every person examined written into it. Sometimes a record log-book will have columns drawn down two pages – each column will be for a specific detail.

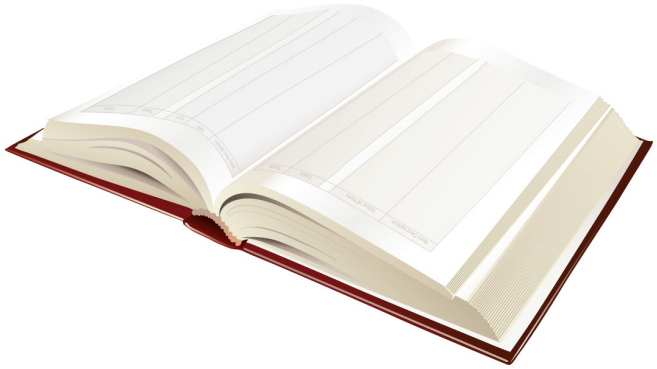


Figure 22.2: *A large book can have columns drawn down both pages to make a record log-book for eye examination records*

Record log-books can also be useful for students who are making an examination portfolio for assessment or registration purposes.

The headings for each column of a log-book can include:

- Date
- Name
- Date of birth (DOB)
- Male/female
- Chief complaint
- Case history
- General health
- Family history
- Occupation / Tasks
- VA (R & L): Distance and near
  → presenting, pinhole, unaided, aided
- Eye health
- Interpupillary distance (PD)
- Refraction
- Diagnosis
- Treatment recommendations (including spectacles)
- Advice given to the person
- Referral (if necessary)
- Name of examiner

If the record of a person's eye examination is lost it can cause serious problems.

Because record cards are single pieces of paper, they can easily be lost. If you use a record card system you must make sure that you have a good filing system that is used correctly.

It is more difficult to lose a log-book record. If the person knows the date that their eyes were last examined the record can always be found somewhere in the log-book.

Some eye clinics choose to use both a record card and a record log-book to be safe.

EXAMINATION RECORD (cont.)

COMPUTERISED RECORD	Some clinics now use computer databases to record the details of people who are examined. It can be easier to find a person's record on a computer database, and examination reports and referral letters can be generated directly from a computerised record. If a computerised record is used, care must be taken to make sure that information is not deleted or changed by accident. Back-ups of the computer databases need to be made regularly in case the computer is broken or stolen. Information can also be lost if the electricity stops unexpectedly. Computerised records are extremely inconvenient if outreach clinics are performed as the information (written on paper) must be transferred (typed) into the computer when you return to your clinic. This can waste a lot of time.

REFERRAL LETTERS

Sometimes when you examine a person's eyes you will find a problem that you cannot treat yourself. This person needs to be referred to someone who specialises in that problem.

When a person is referred you must send a referral letter with them. The referral letter is addressed to the eye care provider who will examine them, and should include the following information:

- the reason that you are referring the person
- the parts of the case history and test results that are relevant to the problem
- any treatment (including spectacle prescriptions) that the person has received.

DETAILS TO INCLUDE	• Date that the letter is written • Name (if possible) and address of the eye care provider that you are referring the person to • Name and DOB / age of the person • Address of the person (and name / address of nearest relative) • Main problem (and other problems if relevant) • Relevant case history • Visual acuity • Relevant test results → remember to specify which eye has the problem • Complete details of any treatment given to the person (by yourself or someone else) → spectacle prescription → drug names and dosages (if relevant) • A polite request for advice and treatment • Your name, address, signature, and official title Referrals can be written on blank or letterhead paper, or can be written on a specially made referral form.
REFERRAL LETTERS	If you choose to write a referral letter, it needs to look professional. It must be written neatly (or typed) and be easy to understand.

REFERRAL LETTERS (cont.)

EXAMPLE

Letterhead
(Your eye clinic address)

Mountain Vision Centre
Top Health Clinic
Mountain Town

3 August 2008

Details of the specialist or hospital that you are referring to

Dr Lookgood
Super Eye Hospital
Capital City

Details of the person that you are referring

Dear Doctor

RE: Mrs Flower Garden **DOB: 29/2/1960**
2 Rocky Road, One Tree Village, Mountain Town
Telephone number: 455 6767
Nearest relative: Mr Herb Garden (son) at same address

Summary of reason for referral

Reason for referral: **Scratched Left Eye**

Thank you for seeing Mrs Garden whom I first saw yesterday (2/8/08).
On 2 August 2008 her right eye was injured with a stick while she was gardening.

Mrs Garden complained of a painful, watery right eye.
Unaided VA: RE 6/6 LE 6/6
My examination showed a red right eye with a small scratch on the inferior cornea near the limbus. The left eye looked normal.

I instilled Tetracycline ointment 10% and asked Mrs Garden to return the next morning.

Today (3/8/08) the eye is more red than yesterday and visual acuity for the right eye has decreased to 6/12+2. Mrs Garden tells me that the pain is worse than before.

I am concerned that Mrs Garden's eye has developed an infection. I am referring her to you for urgent advice and further treatment.

Polite request for advice and treatment

Best regards

I. See

Ms Isabelle See
Vision Technician

Your official title

REFERRAL FORM LETTERS	Some people prefer to use a referral form when they refer a person. A referral form can be useful because it helps you to remember all the information that you need to include, but sometimes there is not enough space for all the details. (If more space is needed, you can write on the back of the form also.)

EXAMPLE

Name:	**Mrs Flower Garden**	DOB: **29 / 2 / 1960**	Gender: ☒ F / ☐ M	Date: **3 / 8 / 08**	
Address:	**2 Rocky Road, One Tree Village, Mountain Town. Telephone: 455 6767**				
Case History:	**Painful red right eye. Stick in right eye while gardening. Painful, watery R eye**				
VA distance with spectacles	R: L:	VA distance without spectacles	R: **6/6** L: **6/6**		
VA pinhole	R: L:	VA near with spectacles		VA near without spectacles	
EXAMINATION	Conjunctiva bulbar: **Red** Cornea: **R: small scratch on cornea near nasal limbus.** **L: normal** Pupil: **pupils same size** Lids: **normal** Lashes: **normal** Other:		**IDENTIFICATION DIAGNOSIS** Reasons: **Corneal abrasion, (history: scratch on cornea from plant)**		
TREATMENT	**RE:** **Tetracycline ointment 10%**	**REFERRAL NECESSARY**	☒ Urgent ☐ As soon as possible ☐ Next opportunity		
OTHER	**Patient instructed to return the next morning (3/8/08).** **Follow-up examination (3/8/08):** **VA (unaided) R 6/12+2 L 6/6. Patient reports more pain. Eye more red than previous day.** **Plan: Urgent referral** ← **Could also be written on the back of the form**				
REFERRAL	☐ **For an eye health and general check:** History or symptoms of Diabetes and / or Hypertension	☐ **For an eye health check:** Distance vision 6/18 or worse in either the left or right eye AND does NOT improve to at least 6/9 with pinhole	☐ **Refer for an eye test for their distance vision:** Distance vision is 6/18 or worse in either the right or left eye and DOES improve to at least 6/9 with pinhole		
REFERRAL DETAILS	Referred for: **Because of possibility of an eye infection** Referred to: **Dr Lookgood, Eye Hospital, Capital City** Arrangements made for referral: ☐ Date of appointment: **4/5/04** ☐ Transport: **Son will take her** ☐ Other _____				
Instructions / When to return (Date)					
Please examine and advise. Yours sincerely  **Ms Isabelle See** **Vision Technician**					

SUMMARY: RECORD KEEPING AND REFERRAL LETTERS

EXAMINATION RECORD

- Permanent copy of what was found during the eye examination.
- Any eye care provider who looks at the examination record should know what the person's eye problems were and what was done about them.
- The person's examination record is added to each time they come to you for an eye examination.
- Examination cards contain private information about the people you examine. You must make sure that the information is kept secret.

DETAILS TO RECORD

- Personal details:
  - date, name, DOB, gender, contact details, location of examination.
- Case history:
  - Chief complaint and other symptoms, vision and health history, family history.
- Visual acuity (VA):
  - presenting VA, pinhole VA, unaided VA, aided VA, best corrected VA (for distance and near).
- Examination results:
  - tests performed and their results, refraction and spectacles, eye health.
- Diagnosis and plan:
  - identification of problem, treatment (including spectacles), referral, when to return for a check-up, what the person agreed to.

TYPES OF EXAMINATION RECORD

- Record card:
  - piece of paper or cardboard with the person's eye examination information written on it
  - filed with other people's record cards by name or number.
- Record log-book:
  - also called a line-listing record
  - large book that usually has columns drawn down its pages
  - each column is for a specific detail
  - all the people that you examine will have their examination information written in this book.
- Computerised record:
  - examination information is typed into a computer database
  - must be extremely careful that examination information is not deleted or changed by accident
  - inconvenient if outreach clinics are performed.

TYPES OF EXAMINATION RECORD

- You need to refer people who have a problem that you cannot fix yourself.
- You must write a referral letter for every person whom you refer.
- Referral letters must contain:
  - date
  - name of the person / hospital that you are referring to
  - name, DOB, address of the person
  - details of the problem that you are referring the person for
  - relevant case history
  - VA
  - relevant test results
  - details of any eye treatment that the person has already received (including spectacles)
  - polite request for advice and treatment
  - your name, address, signature, and official title.
- A referral must be typed or carefully handwritten, or you can use a referral form letter.
- A referral form letter is a printed letter with spaces in which you can write the referral information.

TEST YOURSELF QUESTIONS

1. Why is it important to keep good eye examination records?

_____

_____

2. Why should you be careful to keep examination records safe and private?

_____

_____

3. A woman had her eyes examined by you 2 years ago. She comes to you again today to have another eye examination. Do you …

a. add to her previous record? ☐ Yes / ☐ No

b. compare her results from 2 years ago with the results you found today? ☐ Yes / ☐ No

c. throw her old record in the bin? ☐ Yes / ☐ No

d. file the old and the new records together? ☐ Yes / ☐ No

4. Complete the following table.

Type of Record	Advantages	Disadvantages
Record Card		
Record Log-Book		
Computerised Record		

5. List the details that need to be included in a referral letter.

_____

_____

_____

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_____

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