RECORD KEEPING

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THINK

A child you saw two years ago has a scar on the cornea.

You need to know:

- If this is a new or old scar?
- If somebody else has examined the child before?
- What tests were performed?
- What the results were?

WHAT YOU WILL LEARN

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

- Recognise the importance of keeping a record
- List the details that should be included in a record

RECORD KEEPING

- A record is a document that provides information about a person's eye test.
- Records are important as they allow you to keep a permanent copy of what happened each time the person visited you.
- 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.
- 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.
- It is important that the information that is written on the record is written neatly and can be easily understood.
- Record cards can be filed by name or by number.

WHAT DO WE NEED TO RECORD

WHAT INFORMATION IS IN A RECORD?	
DETAILS OF THE PERSON:	The date of each visit The person's full name The person's date of birth or age (if known) Male or female Contact details (address, phone number) Where you saw the person (name of hospital, clinic or other).
CASE HISTORY:	A summary of the information gathered about the patient ▪ Chief complaint and history ▪ Eye health and family history ▪ General health and medication ▪ Visual needs ▪ Distance and near vision.
VISUAL ACUITY:	Visual Acuity measured at distance and near ▪ With their own spectacles (aided) ▪ Without spectacles (unaided)
EXAMINATION:	What you saw and did during the examination Details of the person's eye health
PLAN:	What you identified to be the problem and how you intend to manage it ▪ Prescription of spectacles and medication ▪ Referral
ADVICE:	What you told the person ▪ Explanation of their symptoms / your findings ▪ Medication / treatment plan and why you have decided on this mode of action ▪ When to use the medication or follow the course of treatment ▪ In cases of referral and explanation as to why they need to be referred and when they need to return for a follow-up visit.
SIGNATURE	▪ You must complete the record by printing and signing your name. ▪ It is not a legal document unless it is signed by the examining practitioner

RECORD THE RESULT EVEN IF IT IS NORMAL

- This means that you should write down positive findings as well as negative findings e.g. distance vision is good or cornea is clear.
- This shows that you have done the test.

If a box has been left empty on the record form, it means the test was not done.

TEST YOURSELF QUESTIONS

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

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2. **Why is it important that the information on the record card be written neatly?**

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3. **What information do we need to write in our record card about a person?**

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4. **Why is it important to write down facts even if they are normal?**

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