

SCHEDULE 5

Regulation 2(1)

RECORDS

1. An ophthalmic medical practitioner or optician shall keep the following data in records (this data is a record of patient details, symptoms, tests performed and results thereof):-

Personal Patient Data	Name, title, address, telephone number, Date of Birth, General Practitioner's details, occupation, driver Yes/No, hobbies
Symptoms & History	Presenting signs & symptoms, past ocular history, past medical history, family ocular and patient's own medical history, medication, reason for referral to or from the ophthalmic medical practitioner or optician, Smoker Yes/No
External Examination	A record of all relevant findings
Internal Examination	A record of whether this was with or without mydriasis, the apparatus and diagnostic agents used, and a description of the ocular media, fundus, blood vessels, optic disc and macula
Pupil Assessment	Relative afferent pupillary defect, direct, consensual and near responses, pupil size and shape
Extra Ocular Motor Function	Cover test, convergence, muscle balance, motility, stereopsis, amplitude of accommodation results
Visual Fields	Record relative findings, apparatus, confrontation
Intra Ocular Pressure	Intra ocular pressure measurement, contact or non-contact
Refraction	Objective/subjective findings, unaided vision, pinhole acuity, visual acuity, back vertex distance, prescription issued, spectacle, dispensing details
Colour Vision	Record findings and test procedure
Imaging	Record reference to any electronic images taken
Supplementary Additional Procedures	Note the reason for any supplementary or additional procedures
Diagnosis / Findings	Make a record of all findings and any diagnosis
Communication	Note any advice, statements, reports or referrals issued to the patient or made on behalf of the patient.
