ANNEX C

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 (primary eye examination)	Name, title, address, telephone number, Date of Birth, General Practitioner's details, Community Health Index number (where available), occupation, driver Yes/No, relevant interests, date of examination
Symptoms & History (primary eye examination)	Presenting signs & symptoms and reason for visit, 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 (if relevant), if family history, or symptoms of age related macular degeneration.
Personal Patient Data (supplementary eye examination)	Update of Name, title, address, telephone number, General Practitioner's details, occupation and date of examination
Symptoms & History (supplementary eye examination)	Presenting signs & symptoms, reason for visit or for referral to or from the ophthalmic medical practitioner or optician, update of ocular and medical history and medication
For all eye examinations:	
Diagnosis / Findings	Record of all findings and any diagnosis or outcomes. Record of reason why any specified/expected procedure or test was not carried out. Where digital fundus photographs have been taken, the photographs should be retained either in electronic form or in hard copy and backed up either in electronic form or hard copy. Where a drug has been issued to a patient, a record of the batch number of that drug, the expiry date and the date when that drug was administered to the patient should be kept, either in the patient record or in a register held at the practice for the specific purpose of recording the drugs which have been administered.
Communication	Note any advice, statements, reports or referrals issued to the patient or made on behalf of the patient
Data to be recorded where appropriate for tests and procedures specified in the Tables A and B in Schedule 3 and the Table in Schedule 4:	
External Examination	A record of all relevant findings, technique and apparatus used
Internal Examination	A record of whether this was with or without mydriasis, the technique, apparatus and diagnostic agents used and a full description of the ocular media, fundus, blood vessels, optic disc and macula

Neurological Assessment	All relevant tests undertaken, which may include pupil assessment – relative size, shape, direct, consensual and near responses
Oculo-Motor Function	All relevant tests undertaken which may include cover test, convergence, muscle balance, motility, stereopsis, amplitude of accommodation
Visual Fields	Record findings, technique and apparatus used
Intra Ocular Pressure	Intra ocular pressure measurement, type of tonometer and time of measurement
Sight test	Objective/subjective findings, unaided vision, pinhole acuity, visual acuity, back vertex distance (over 5D), prescription issued, dispensing details
Colour Vision	Record findings and test procedure
Imaging	Record reference to any electronic images taken. Where any electronic images have been taken, the image should be retained either in electronic form or in hard copy and backed up either in electronic form or hard copy."