Primary Eye Care Examination Standards

The basic eye examination, should be recorded in the Subjective/Objective/Assessment/Plan (SOAP) format or Assessment/Plan/Subjective/Objective (APSO) format within the electronic health record (EHR) and should include:

I. SUBJECTIVE.

A. Chief Complaint(s).
B. History to include at a minimum:
  1. History of present illness(es).
  2. Ocular history to include at minimum; eye injuries, eye surgeries, and eye diseases.
  3. Significant family history of; diabetes, hypertension, glaucoma, blindness, and macular degeneration.
  4. Current medications.
  5. History of medication allergies and reactions.

II. OBJECTIVE.

A. Visual Acuity Measurement.
B. Ophthalmoscopy as indicated.
C. Refraction as indicated with best corrected visual acuity recorded.
D. Pupil responses.
E. Evaluation of gross muscle function (motility).
F. External examination of the eye and adnexa.
G. Slit lamp examination of the anterior segment and posterior pole using appropriate diagnostic lenses.
H. Intraocular pressure.
I. Dilated retinal examination findings including documentation of the C/D ratio, macula, and peripheral retina as indicated. If unable to do so at an initial or annual visit, the reason should be documented and the patient should be scheduled for follow-up to ensure a complete examination is performed.
J. Adjunctive testing as indicated by the examination to include, but not limited to, fundus photos, visual field and OCT testing.

III. ASSESSMENT.

List of all diagnoses.

IV. PLAN. A treatment plan which includes at least:

A. Treatment Plan.
B. Follow-up.
C. Referral to other specialties if indicated.
D. Patient education.