Five “Things” You Need To Know

Being a good tech is not enough!

When you are working up a patient, you should be able to look at that chart a year later and have a "picture" of that patient and the exam. You are the eyes and ears for the doctor - observing the patient and hearing the things that they might not tell the doctor.

Think about it.....

Has the patient ever told you that they only use their Timoptic QD instead of BID because it was too expensive - and ended the sentence with.." but don't tell the doctor because he'll get mad" ?!

... and you nodded and smiled, and then as the two of you were giggling, proceeded to write it in the chart!!

You would never "hide" that information from the doctor. It would be like hiding an APD or not checking anterior chamber depth prior to dilating the patient.

Histories & Chief Complaint

* "Story of a patient's medical disorder" (Stein and Slatt)
  * A series of specific questions linked together in an orderly sequence
  * Do not interpret or expand a statement.
  * Continue to build on the responses in order to paint a picture of that patient and their health history

Chief Complaint

* One or two sentences used to describe the main reason the patient is in your office today.
* Put it in the patient's words!
  * I see cobwebs in my left eye
  * I don't see good at night driving. Maybe I need stronger glasses
* It is not: routine eye exam, post op visit, (6) month recheck. These are appointment types, not reasons.
The history is a vital part of the doctors’ exam. They will use your information and then expand on it. You are giving them a road map to where the patient wants the exam to go – and a map where the doctor needs to medically go. Patients will often tell you things that they won’t tell the doctor – especially regarding compliance with their medications!

STOP THE MADNESS

Obtaining a history is a question and answer process – a conversation between two people.

DO NOT CARRY FORWARD INFORMATION !!!

Key Words to Use

Denies……..When asking about allergies, medications, surgeries, past medical history… "patient denies allergies"  
Denies implies that you asked the patient and they denied it. Otherwise, this sign means "nothing" – you might not of even asked, you might have carried the information forward!

Process

* Chief Complaint  
* History of Present Illness  
* Allergies (in red)  
* All Medications  
* Past Eye Health (injuries, surgeries, dates)  
* Past General Health (surgeries and dates)  
* Family History (eye, Ca, DM, Heart)  
* Social (smoking/drinking/occupation)

“Document it. If you haven’t documented it, you didn’t do it.”

- Consultation was requested by Dr. Welby  
- Note for John Doe on 2/10/05 - Chart 1124  
- Chief Complaint: This 26 year old male presents today for flashers and floaters in their left eye x 2 days. "Like lightning"  
- Allergies: Patient admits allergies to aspirin resulting in disorientation, GI upset  
- Medication History: Patient is currently taking amoxicillin-clavulanate 125 mg-31.25 mg tablet, chewable medication was prescribed by A. General Practitioner MD, Advil-0.5 mg tablet medication was prescribed by A. General Practitioner MD, Vioxx 12.5 mg tablet (BID).  
- PMH: denies heart, asthma, surgeries for tumors or stroke  
- Past Surgical History: Patient admits past surgical history of (+) appendectomy in 1989.  
- Social History: Patient denies alcohol use. Patient denies illegal drug use. Patient denies STD  
- Family History: Unremarkable.  
- Review of Systems: Eyes: dry eyes eye or vision problems blurred vision  
- Symptoms: constitutional symptoms such as fever, headache, nausea, dizziness Musculoskeletal  
- joint or musculoskeletal symptoms
Vision

Snellen E Chart:
The eye can identify two points separated by an angle of 1 minute to the eye. The chart is made so that the sections of a letter subtend 1 minute of arc. Each letter is printed on squares made up of 5 parts, so that the whole letter subtends a 5 minute angle to the eye.

• Distance used is 20 feet or 6 meters
• Recorded as a fraction:
  \[ \frac{20}{40} \]
  \[ 20 = \text{distance} \]
  \[ 40 = \text{distance at which a normal person can read the chart. So... 20/40 means a person can see at 20 feet what a normal person can see at 40 feet.} \]

Order of Documentation

“Read me the smallest line you can see”
answer: 20/70 - 2 - ph NI
or
Can't see any letters...
* Walk chart to the patient. Sees E at 7 feet... note 7/200
Can't see chart at all... then...
Count Fingers (CF) (done at near approx 1-2 ft)
Hand Motion (HM)
Light Perception (LP)
No Light Perception (NLP) ...
If your clinic has never seen the patient before... have MD make the diagnosis and check pupils!!

Refraction Pitfalls

Emmetropia: No refractive error
Ametropia: Refractive error either myopia, hyperopia or astigmatism
Myopia: Nearsighted
Hyperopia: Farsighted
Astigmatism: Light rays not refracted equally in all directions
**Myopia**: light is focused in front of the retina

**Hyperopia**: light is focused behind the retina

**Astigmatism**: light rays not refracted equally

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**Refraction vrs. Refractometry**

*Refraction*: The sum of the subjective and objective steps that leads to a decision by the physician of a prescription.

*Refractometry*: Measurement of the refractive error.

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**“Sins” When Performing Refractometry**

When I was learning refractometry, I was told the #1 sin was over minusing the patient. I actually believe the #1 sin is “under plussing” a patient, followed closely by “over minusing” - and in both cases - they occur for this main reason......listening too much to what the patient “wants” and not giving them what they “need”!

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**Underplus**

Common complaints:

* I used to love to read but now I am so tired at the end of the day it’s no fun
* I used to wear glasses when I was younger but I outgrew it
* I am 33 years old and need bifocals to read

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Hyperopic eyes are what I call *martyr eyes*. They need glasses - but their brain doesn't want the help. So, the brain works and works to keep things in focus. They get tired and some people even complain of headaches or upset stomach. They are not hurting themselves, they are “bugging” themselves.

Be careful of listening too much to what they “want”. They may “need” +3.50 to correct their hyperopia, but their brain might tell them they only need +1.00.

**My Personal Best**: gentleman came to our office (5) times in a year with the same complaints. 34 y.o. (5) different techs. He “wanted” to be a -3.00sp... he “needed” to be a +4.50sp 😊
**Over Minus**

Myopic eyes are “piggy eyes”. They want all the anatomical power present and more. They don’t need more... they just want it. If you give it to them, and they are under 35 y.o. or so, they usually don’t have an issue (except for the fact you have given too much power). After 35 or so, they begin to have issues with reading, and will tell you they take their glasses off to read !!!!

So, in this case, you are listening too much and doing what the patient “wants” – and not doing what they need. When you are refining, ask them: “better one, better two or about the same”... if you don’t give them an out, they will continue to pick more minus because it makes it look darker – and to the brain - darker is better.

**What Is The Answer ??**

The best way to know if over minusing or someone is the retinoscope. The retinoscope will give you the anatomical answer to what the patient’s true refraction is. Then you do a minimal subjective “one or two”. That way the patient gets what I see (what they need) and not what they want (over minus or under plus)!

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**Pearls**

- "If it ain’t broke, don’t fix it”

If a patient states they see well, no complaints, and their vision is good (20/30 or better), don’t make big changes to their Rx unless they "need" it! My gentleman actually saw 20/25 with his wrong Rx – he was just miserable. For example:

**original**: -1.00+0.75 x 180 (20/25-2)  
**new**: -1.75 + 1.25 x 21 (20/25+2)

When I asked the tech why the big change - the answer was ?????????????????

**And... More Pearls**

- Don’t give them what they want, give them what they need.
- Learn to retinoscope!
- Listen to the patients complaint – and then find the answer for the complaint.
- For every 0.25D you give a patient - they should improve one line.
- Patients will tolerate bigger changes to their sphere than they will to their cylinder and axis. Make sure it’s a good change!

**Pupils**

Pupils should be checked on all patients that are being dilated every time!

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**Get Rid Of The Disposable Pen Lights!**

Get a transilluminator or a battery operated penlight - one that is brighter and more reliable than the disposable ones.

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**Afferent Pupillary Defect (APD)**

- Glasses off
- Lights dim
- Do not stand directly in front of the patient
- Light close to eye
- Patient fixates in the distance
- Takes longer than 2 seconds!

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**Stop The Madness!**

1. Anyone that has \(20/80\) vision or worse - assume they have an APD until proven otherwise.
2. What? NLP that have normal pupils...see #1
3. Just because the patient has been to your office every week for (2) years and has never had an APD - doesn't mean that he doesn't have one today!
4. IF you have never seen the patient - assume an APD has been missed if any of the above.

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**Anterior Chamber Depth Assessment**

Techs often say that they are "checking the angle" prior to dilating a patient. They are actually checking the anterior chamber depth.

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**Anterior Chamber**

Anterior chamber is that space from the back of the cornea to the iris.

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**Why Is This So Important?**

The pupil acts like an accordion... when you dilate the pupil, it expands and collapses outward toward the angle. IF the anterior chamber depth is narrow to begin with, you can close the angle off causing a closed angle glaucoma attack!
**Angle Closure Glaucoma**

Patient complains of headache ("ice cream headache"), nausea, decrease vision due to steamy cornea.

**Use The Slit Lamp NOT The Pen Light!**

The slit lamp gives you a fine slit to evaluate depth. The penlight casts a white "ball" of light so that you can back illuminate the anterior chamber to estimate depth.

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**People Skills**

**Who do you work for?**

- The Doctor
- Your Supervisor
- Money

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**THE PATIENT**

If this is how you treat your patients... you don't listen to them or don't acknowledge how they view their medical experience... Change Jobs ASAP
It's a simple fact... if you lose a patient because they were dissatisfied, unhappy, disrespected or confused by your treatment plan for them - you actually lose 5 - 6 people. They will tell their friends and family how "poorly" you treated them!

If you treat everyone like your family - how you would want someone to treat your family... you will always do a good job!