EXAMPLE OF DOCUMENTATION TO SUPPORT CODE REPORTED

DATE

RE:
Exam Date:
Patient's Date of Birth:

Dear :

This report will provide you with a summary of pertinent clinical findings and observations from my examination. It is a pleasure to have the opportunity to share in the care of this patient.

EXAMINATION: Pediatric eye health and vision examination, Visual Skills Examination. Last examination: Never.
OTHER DOCTOR:
SPECIAL CIRCUMSTANCES: Reviewed previous doctors notes from Dr X Patient here with father and mom on phone. Patient referred for visual skills evaluation. Also reviewed report from
OCCUPATION: Student Kindergarten
Visit Location: Office
CHIEF COMPLAINT: Referred for Eye Health Evaluation, Physician directed visit for specific problem, Visual Skills evaluation, Trouble with learning, Skipping around when reading.
VISION COMPLAINT: Bilateral: Without spectacle correction Vision may have changed. Difficulties are not problematic.
VISUAL SYMPTOMS: Bilateral: Cannot read comfortably for long periods. Poor eye-hand coordination. Misreads words. Trouble with retention and recognition of letters and words
OCULAR SYMPTOMS: Bilateral: No ocular symptoms.
DOCUMENTATION OF MEDICATIONS: Documented medications.
REVIEWED MEDICATION ALLERGY HISTORY: Medication allergy reconciliation performed.
OCULAR HISTORY: OK (None).
MEDICAL HISTORY: No pertinent past medical history exists.
SYSTEMIC SURGICAL HISTORY: No pertinent past surgical history exists.
SYSTEMIC FAMILY HISTORY: No pertinent medical history exists.
OCULAR SURGICAL HISTORY: None.
OCULAR FAMILY HISTORY: Family history is reported to be unremarkable.
OCULAR MEDICATIONS: No reported ocular medications., No known ocular medication allergies
ALLERGENS: pollen (per patient)
SYSTEMIC MEDICATIONS: Multivitamins, No known systemic medication allergies.
SOCIAL HISTORY: No reported use of tobacco, alcohol or narcotics.
DEVELOPMENTAL HISTORY: Normal term birth. Full-term pregnancy. Normal birth. Normal activity. Learning difficulties exist. Speech developed normally. Reduced fine-motor development. Behavior is appropriate with age level. General physical appearance is unremarkable. Receives OT for motor support
SPECTACLE Rx STATUS: Bilateral: No current Rx. No prior vision Rx.
REVIEWED HISTORY: I have reviewed this patient's previous exam records. I have reviewed this patient's history encounter form. Documentation scanned and attached to patient's record. Medication reconciliation performed for transition of care.
ALLERGY: No allergies or drug hypersensitivities are reported. No medication allergies are known to exist.
CARDIOVASCULAR: Current Status: No symptoms reported at this time.
RESPIRATORY: Current Status: No symptoms reported at this time.
REVIEWED ROS: I have reviewed this patient's ROS encounter form.

SAMPLE

UNAIDED ACUITIES:
RT: DVA 20/20 NVA 20/20
LT: DVA 20/20 NVA 20/20

COVER TEST (DIST): Method: Alternate Horz: Ortho
COVER TEST (NEAR): Method: Bilateral Horz: 3.00XP
NEAR PT CONVERGENCE: Method: Push Up Break: 0
FUSION: Method: Worth Test Dist: 4 Near: 4 Fusion
STEREOPSIS: Method: Randot Near: 100"
PHORIA (DIST): Method: Von Graefe Horz: 1.00EP
PHORIA (NEAR): Method: Von Graefe Horz: Ortho
RELATIVE ACCOMMODATION: NRA - Blur: +2.00 PRA - Blur: -2.00
NEAR POINT CONVERGENCE OBSERVATIONS: Patient inattentive
FUSION OBSERVATIONS: Fusion Exists, comitant in 9 fields of gaze
STEREOPSIS OBSERVATIONS: 3/6 circles

RETINOSCOPY:
RT: +0.50
LT: +0.50
MANIFEST:
RT: +0.25 DVA: 20/20 NVA: 20/20
LT: +0.25 DVA: 20/20 NVA: 20/20
BI: DVA: 20/20 NVA: 20/20

CUP/DISC RATIO:
RT: Horz .15 Vert .15
LT: Horz .15 Vert .15
WEIGHT (POUNDS): 38
HEIGHT (INCHES): 43
TONOMETRY: RT: Soft mmHg LT: Soft mmHg Test: Digital Time: 04:30 PM Category: Examination
DILATION ORDERS: DFE performed with 1% Myd using BIO and SLE w/Volk lens. Told of Side Effects. @04:30 PM
INTRA OCULAR TENSIONS OBSERVATIONS: Considering all other factors, risk of glaucoma is low, Globe palpation performed, and found to be soft.
CONFRONTATION FIELDS OBSERVATIONS: Fields were found to be full in all quadrants, OU
EXTRAOCULAR MUSCLES: Bilateral: Ocular motility assessment; full and unrestricted. Saccades, undershooting noted. Pursuits, mild fixation loss. Extraocular motilities full and unrestricted. Testing reveals convergent misalignment. Degree of deviation is mild. Degree of deviation is greater at near. Frequency of deviation is intermittent. Uncorrected hyperopia indicate accommodative factors. Obtain sensorimotor exam.
EYELASHES: Bilateral: Slit lamp observations include: Eyelashes are normal.
EYELIDS: Bilateral: Slit-lamp observations include: Eyelids are normal with complete closure upon blink.
PUPILS: Pupils are equally round, reactive to direct, consensual and near stimulation. No afferent pupillary defect is noted.
ORBIT: Bilateral: The orbit is normal.
CORNEA: Bilateral: Slit lamp observations include: Corneal epithelium, stroma, endothelium, tear film, clear and healthy.
CONJUNCTIVA: Bilateral: Slit lamp observations include: Bulbar and palpebral conjunctiva are healthy and white.
IRIS: Bilateral: Slit lamp observations include: The iris appears healthy with normal anatomy and convexity.
LENS: Bilateral: Slit lamp observations include: Lens, both capsules, cortex, and nucleus are normal for age.

SAMPLE

VITREOUS: Bilateral: Slit lamp observations include: The vitreous is normal.
OPTIC NERVE: Bilateral: Slit lamp examination: Optic disc appears normal. Disc margin is distinct.
MACULA: Bilateral: The macula appears flat with no abnormalities.
RETINA: Bilateral: Retina is flat, attached and normal.
VISUAL EFFICIENCY: Bilateral: There is an inflexibility of accommodative function. See EOM for motility details. Saccades 3+, slight undershoot. Pursuits 1+, three fixation losses. Visual Perceptual skills testing is abnormal.
DISPOSITION: This patient's mood is pleasant and sociable.
ORIENTATION: Patient is fully alert to time, place, and person. Recent and remote memory is fully intact.
COLOR DISCRIMINATION: Bilateral: Color vision was found to be normal. Testing, Ishihara pseudoisochromatic plates.
SENSORIMOTOR EXAM: Bilateral: Neuromuscular defect in extra-ocular muscle alignment found. Instrumentation and techniques utilized: Cover Test. Maddox Rod. Phoropter. Prism Verification. Rotary Prism. Stereo acuity. Worth 4 dot. EOM defect exists: Eye turns in. Deviation is: Accommodative related. Defect is mild. Patient cooperation was good and tolerated the procedure well. Defect is consistent with convergence excess. See EOM findings and binocular findings for testing results. Plan: Follow for trend analysis as directed and treatment as indicated in plan.

IMPRESSION(S):
Bilateral: Convergence excess
Bilateral: Eye movement disorder
Other specific learning difficulties
Reading disorder
Hyperopia

TREATMENT EXTRAOCULAR MUSCLES: Bilateral: Monitor condition at suggested intervals. Instruct patient to immediately report any change in condition outside of expected and discussed symptoms. Discussed options of glasses versus therapy. After thorough discussion, parents decided against glasses at this time. Parents referred to occupational therapy for management of binocular vision difficulties impacting performance.
SPECTACLE PLAN: Bilateral: Postponed spectacle Rx. Advised that glasses are sometimes considered for convergence excess but not recommended as the findings were so minimal in relation to the chief complaint.
TREATMENT VISUAL EFFICIENCY: Rx visual motor skills training as directed. Refer to occupational therapist. Refer to MD/DO specializing in behavioral disorders. Continue with OT to work on oculomotor and visual motor skills. Discussed that the visual findings were minimally impacting performance today. Advised that Dr X and OT reports document visual processing disorders that may be impacting the learning of letters and comprehension. I further suggested continuing Dr direction and consider language therapy assessment to help with this deficit.
COUNSELING: Counseling has been provided to review this patient's case and discuss options for treatment.
COUNSELING / EDUCATION: I have verbally discussed my clinical findings and recommendations in detail with this patient. They acknowledge that they do not have additional questions.
ORDERS:
Recall on or about 12/29/2022: Test: Sensorimotor Examination (TODAY) Ordered by: Entered by:. [Active] on 12/29/2022 By
Recall on or about 05/29/2023: Examination: Vision Therapy Progress Examination Ordered by: Entered by: [Active] on 12/29/2022 By
Recall on or about 12/29/2023: Examination: Eye Health and Vision Exam or prn Ordered by: Entered by: [Active] on 12/29/2022 By

PROFESSIONAL CORRESPONDENCE: DATE TIME PM Auto Letter to:

SAMPLE

ELECTRONIC SIGNATURE: Electronically Signed By: on DATE TIME

Completed Exam: _____ Date:
Dr.

Thank you,

Note: The information contained in this report is confidential. Unauthorized disclosure may result in civil/criminal action as provided by HIPAA (1996) regulations.

SAMPLE

EXAMPLE OF DOCUMENTATION TO SUPPORT CODE REPORTED

DATE

RE:
Exam Date:
Patient's Date of Birth:

Dear :

This report will provide you with a summary of pertinent clinical findings and observations from my examination. It is a pleasure to have the opportunity to share in the care of this patient.

EXAMINATION Adult eye health and vision examination. Last examination: 1-2 years ago.
REFERRED BY:
SPECIAL CIRCUMSTANCES: patient having hernia surgery this friday. Seen by Dr XXXX last week ago. Talked about TIA and told ocular migraines
OCCUPATION: Owner of XXXX
Visit Location: Office
CHIEF COMPLAINT: Referred for Eye Health Evaluation, LT: Reports floaters, Reports blurred vision at distance and near.
VISION COMPLAINT: Bilateral: With current spectacle correction A noticeable decline or change in vision is experienced. Problems are experienced primarily at distance. Reading-range has become especially difficult. Patient feels that current Rx requires updating.
OCULAR SYMPTOMS: Bilateral: No ocular symptoms.
FLOATERS/FLASHES: Left Eye: FLOATERS: Reporting continued observations. Symptoms seem to be lessening.
DOCUMENTATION OF MEDICATIONS: Documented medications.
REVIEWED MEDICATION ALLERGY HISTORY: Medication allergy reconciliation performed.
VERIFICATION OF MEDICATIONS: Verified medications.
OCULAR HISTORY: BI: Early Cataract, LT: Vitreous Detachment, July 2019, OD: Amblyopia, OD: Occlusion Therapy, RT: vitreomacular traction, Ocular Migraine.
No pertinent past medical history exists.
SYSTEMIC SURGICAL HISTORY: Heart Surgery, April 2021.
SYSTEMIC FAMILY HISTORY: No pertinent medical history exists..
OCULAR SURGICAL HISTORY: None.
OCULAR FAMILY HISTORY: Family history is reported to be unremarkable..
OCULAR MEDICATIONS: No reported ocular medications., No known ocular medication allergies
ALLERGENS: No known non-medication allergens.
SYSTEMIC MEDICATIONS: Aspirin (81mg), No known systemic medication allergies, Co Q 10 [DISCONTINUED] , Eliquis [DISCONTINUED] , Fish Oils [DISCONTINUED] , Multivitamins [DISCONTINUED] , Red Rice Yeast [DISCONTINUED] , Vitamin D [DISCONTINUED] , Vitamin E [DISCONTINUED]
SOCIAL HISTORY: Former smoker. Stopped smoking 10+ years ago, No counseling given regarding tobacco use, Alcohol, average, reporting one-two drinks daily.
SPECTACLE Rx STATUS: Bilateral: Progressive multifocal. Eyewear worn most of the time. Rx updated at last exam.
REVIEWED HISTORY: Medication reconciliation performed.
ALLERGY: No allergies or drug hypersensitivities are reported. No medication allergies are known to exist.
CARDIOVASCULAR: Current Status: No symptoms reported at this time.
RESPIRATORY: Current Status: No symptoms reported at this time.
REVIEWED ROS: I have reviewed this patient's ROS encounter form.

UNAIDED ACUITIES:
RT: DVA 20/50
LT: DVA 20/50
PRESENTING SPECTACLE Rx: (Progressive)
RT: +2.25 -0.50 x 075 Add: +2.25 DVA: 20/40+ NVA: 20/40
LT: +2.25 -0.50 x 090 Add: +2.25 DVA: 20/30- NVA: 20/30

K-READINGS:
RT: 41.50 @ 114 Steep 42.25 @ 24
LT: 41.50 @ 80 Steep 42.25 @ 170

SAMPLE

COVER TEST (DIST): Method: Alternate Horz: Ortho
COVER TEST (NEAR): Method: Bilateral Horz: 4.25XP
NEAR PT CONVERGENCE: Method: Push Up Break: 3

MANIFEST:
RT: +3.00 -1.00 x 080 Add: +2.25 DVA: 20/30+ NVA: 20/40
LT: +3.50 -1.50 x 085 Add: +2.25 DVA: 20/20- NVA: 20/25
FINAL SPECTACLE Rx: (Progressive)
RT: +2.75 -1.00 x 080 Add: +2.25 DVA: 20/30+ NVA: 20/40
LT: +3.25 -1.25 x 085 Add: +2.25 DVA: 20/20- NVA: 20/25

CUP/DISC RATIO:
RT: Horz .25 Vert .25
LT: Horz .25 Vert .25
BLOOD PRESSURE / PULSE: 138/91 76
WEIGHT (POUNDS): 168
HEIGHT (INCHES): 68
TEMPERATURE (FAHRENHEIT): 98.6
TONOMETRY: RT: 18 mmHg LT: 20 mmHg Test: Goldmann Time: 11:41 AM Category: Examination
VISUAL FIELDS SCREENING: Bilateral: Digital perimetry demonstrates normal threshold values in the programs tested.
DILATION ORDERS: DFE performed with 1% Myd using BIO and SLE w/Volk lens. Told of Side Effects. @11:41 AM
INTRA OCULAR TENSIONS OBSERVATIONS: Instilled Fluress.
CONFRONTATION FIELDS OBSERVATIONS: Fields were found to be full in all quadrants, OU
EXTRAOCULAR MUSCLES: Ocular motility assessment; full and unrestricted. Extraocular motilities full and unrestricted.
Right Eye: Testing reveals convergent misalignment.
EYELASHES: Slit lamp observations include: Eyelashes are normal.
EYELIDS: Eyelids are normal with complete closure upon blink.
LACRIMAL SYSTEM: Right Eye: Mild tearing is noted.
Left Eye: The lacrimal system appears normal.
PUPILS: Pupils are equally round, reactive to direct, consensual and near stimulation. No afferent pupillary defect is noted.
HEADACHE: Bilateral: Normal ocular exam. Blood pressure normal. Positive spontaneous venous pulsation noted indicating intracranial pressure is less that 180mm Hg at that moment.
ORBIT: The orbit is normal.
CORNEA: Slit lamp observations include: Corneal epithelium, stroma, endothelium, tear film, clear and healthy. Lipid deposition exists at basement membrane near limbus.
CONJUNCTIVA: Bulbar and palpebral conjunctiva are healthy and white.
IRIS: The iris appears healthy with normal anatomy and convexity.
CATARACT: Bilateral: Lens, both capsules, cortex, and nucleus are normal for age. The lens nucleus shows clouding and sclerosis. Mild opacification exists.
VITREOUS: Bilateral: Slit lamp observations include: The vitreous is normal. A few floaters are noted in the vitreous cavity.
OPTIC NERVE: Optic disc appears normal. Disc margin is distinct.
MACULA: Right Eye: Calcified drusen are noted. Alterations of the pigment epithelium are noted.
Bilateral: Focal atrophy/thinning of the macular structure is noted.
RETINA: Retina is flat, attached and normal.
AMBLYOPIA: Right Eye: Constant monocular decrease in vision. Vision is reduced despite correction. Degree of vision loss: slight. Past history of occlusion therapy. Vision has not changed since childhood.
DISPOSITION: This patient's mood is pleasant and sociable.
ORIENTATION: Patient is fully alert to time, place, and person. Recent and remote memory is fully intact.
SCANNING LASER OPHTHALMOSCOPY (RETINA): Right Eye: Epiretinal defect noted. OCT analysis is consistent with vitreo-macular traction.
Bilateral: CPT 92134 - Interpretation and Report: Macular. Defect is consistent with dry macular degeneration. Early dry stage Plan: Follow for trend analysis as directed and treatment as indicated in plan.
COLOR DISCRIMINATION: Bilateral: Color vision was found to be normal. Testing, Ishihara pseudoisochromatic plates.

IMPRESSION(S):
Right Eye: Congenital esotropia
Bilateral: Subjective visual disturbance-Transient vision loss
Right Eye: Stenosis of the puncta-Condition is stable
Corneal arcus
Bilateral: Senescent cataracts;-Nuclear sclerotic cataract

SAMPLE

Bilateral: Age-related vitreous degeneration-Posterior vitreous detachment
Right Eye: Vitreo-macular traction
Bilateral: Non-exudative macular degeneration Early dry stage The severity of the macular condition is mild
Right Eye: Amblyopia - strabismic Condition is stable
Hypertension suspect
Hyperopia
Astigmatism
Presbyopia

TREATMENT BLOOD PRESSURE: Consult alternative/primary care physician
TREATMENT EXTRAOCULAR MUSCLES: Monitor condition at suggested intervals. Instruct patient to immediately report any change in condition outside of expected and discussed symptoms.
TREATMENT VISION LOSS: Bilateral: Monitor condition at suggested intervals. Patient instructed to RTC if symptoms worsen or do not respond as discussed.
TREATMENT LACRIMAL SYSTEM: Right Eye: Instruct patient to immediately report any change in condition outside of expected and discussed symptoms. Monitor condition at suggested intervals.
TREATMENT CATARACT: Bilateral: Patient counseled about the nature of cataract vision loss. Recommend deferring surgery until functional vision is worse. Monitor condition as directed.
TREATMENT VITREOUS: Bilateral: Educated patient on symptoms of retinal detachment. Patient to immediately report change in symptoms and RTC. Instruct patient to immediately report any change in condition outside of expected and discussed symptoms.
TREATMENT MACULA: Bilateral: Imaging services as indicated and monitor condition as directed. Instruct patient to immediately report any change in condition outside of expected and discussed symptoms. 12 months.
TREATMENT AMBLYOPIA/VISION LOSS: Monitor condition at suggested intervals.
SPECTACLE PLAN: Bilateral: Change spectacle Rx. Primary Rx: Progressive lens.
COUNSELING: Counseling has been provided to review this patient's case and discuss options for treatment.
COUNSELING / EDUCATION: I have verbally discussed my clinical findings and recommendations in detail with this patient. They acknowledge that they do not have additional questions.
ORDERS:
Recall on or about 01/26/2022: Test: Optical coherence tomography: Retina (TODAY) Ordered by: DR X
Recall on or about 01/26/2023: Examination: Cataract Follow-up Exam Ordered by: DR X

ELECTRONIC SIGNATURE: Electronically Signed By: XXX on DATE TIME

Completed Exam: _____ Date:
Dr. XXX

Note: The information contained in this report is confidential. Unauthorized disclosure may result in civil/criminal action as provided by HIPAA (1996) regulations.

SAMPLE