Continuing Competence Program
Practice Visit Report

Part 2 – Patient Chart Assessment

Name of Practitioner Being Reviewed:

_____ **Registration No.:**_____

Type of Practice Visit: **[ ] Regular** **[ ] 180 Day Follow-Up**

Name of Reviewer(s):_____

Date of Review: _____

Name or Office Location of Practice Visit_____
Address:

_____
[Postal Code]

Office phone number: [ ] _____ Fax: [ ] _____
Where are Patients Directed for After Hours Care: _____
Usual days of the week worked at this location: M T W R F Sat Sun

[ ] Practitioner declares that the ACO office is advised of all practice locations

[ ] Practitioner declares that their profile and contact information as found on the ACO website is current

[ ] Part 1 – Self Assessment has been fully completed and signed

GENERAL PRIMARY CARE (In-Office Exam) CHART AUDIT MATRIX

A minimum of six (6) charts are to be chosen randomly for audit purposes from the day-sheets within the previous six months. Cases should include general optometric primary care. (At least one patient chart must be photocopied and attached to this report for use by the CCC in their deliberations and discussions.) The Regulated Member must be present when patient charts are being reviewed. "N/A" means not applicable, "X" means no information recorded, "√" means test was performed and "?" means issue will be discussed by the entire Competence Committee at the meeting.

Patient History **Patient Age & Initials** **Date of Exam**	1	2	3	4	5	6	7	8	9	10
Chief Complaint										
Ocular Health and History										
Medical History										
Allergies & Drug Reactions										
Family History/Risk Factors										
Verification of Current Rx										
Are Records Legible										
Aided and/or Unaided Entrance Visual Acuities										
Distance and Near Binocular Function and Ocular Motility										
Objective Refraction										
Subjective Refraction with Obtained Visual Acuities										
External Ocular Health Exam										
Internal Ocular Health Exam										
Pupillary Reflexes										
Intra-ocular Pressures										
Visual Fields (attach copy where appropriate)										
Was Testing Regimen and Diagnosis Appropriate to Exam Findings										
Was Treatment, Referral or Management Plan Appropriate to Diagnosis										
Was Problem Specific Testing Appropriately Carried Out Based on the Patient Complaint and Exam Findings										

Were Computer Defaults used: [ ] Yes [ ] No
If so, where are they used: _____
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Was the examining optometrist readily identified on patient charts?
[ ] Yes [ ] No

Was the patient record legible and in English? [ ] Yes [ ] No

Additional Comments Regarding General Primary Care Charts:

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OUT-OF-OFFICE EXAMS and/or VISION SCREENINGS CHART AUDIT MATRIX

A minimum of five (5) charts involving comprehensive eye exams or vision screenings performed at out-of-office locations (hospitals, schools, etc.) are to be chosen randomly for audit purposes. At least one chart should be photocopied and attached to this review for use by the CCC. N/A means not applicable, X means no information recorded, "√" means the test was performed and "?" means the issue will be discussed by entire Competence Committee at the meeting.

1) Patient Age & Initials 2) comprehensive eye exam or vision screening 3) location of service 4) Date of Exam	1	2	3	4	5
Subjective					
Objective					
Assessment					
Plan					

Additional Comments Regarding Out-Of-Office Exams / Screenings Charts:
(NOTE: Alberta Health may not be billed for Vision Screenings)

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CONTACT LENSES CHART AUDIT MATRIX

A minimum of five (5) charts involving contact lens care are to be chosen randomly for audit purposes from day sheets from three separate days within the previous six months. The 5 chart total should be a mixture of first-time CL patients and existing CL wearers. At least one chart should be photocopied and attached to this review for use by the CCC. N/A means not applicable, X means no information recorded, "√" means the test was performed and "?" means the issue will be discussed by entire Competence Committee at the meeting.

1) Patient Age & Initials 2) HCL or SCL 3) Date of Exam 4) New fit, refit or progress check	1	2	3	4	5
Subjective • Discussion of CL wear and options available to the patient • Discussion of any contra-indications •					
Objective • Assessment of corneal curvature • Over-refraction • Visual acuity • Observance of CL issues					
Assessment • Assessment of the physical fit of the lens • Assessment of physiological response					
Plan • Final CL Specs • Solutions • Instruction session • Wear schedule • Replacement • Expiration date • Recheck					

Additional Comments Regarding Contact Lens Charts:

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IN-OFFICE TREATMENT, REFERRAL OR CO-MANAGEMENT CASES

At least ten (10) charts are to be chosen randomly for audit purposes from day sheets from three separate days within the previous six months. These ten cases should include those patients who were treated in-office, those who were referred to another health care practitioner and/or those who were co-managed with another health care practitioner. The cases may include accommodative / binocular vision, ocular or systemic conditions. The regulated member must be present when patient charts are being reviewed and at least one chart must be photocopied and attached to this review for use by the CCC. "N/A" means not applicable, "X" means no information recorded, "√" means test was performed and "?" means the issue will be discussed by the entire Competence Committee at the CCC meeting.

1) Patient Age & Initials 2) Vision or Medical Condition 3) In-Office Treatment (T), Referral (R) or Co-management (C) 4) Date of Exam	1	2	3	4	5
Subjective					
Objective					
Assessment					
Plan					

IN-OFFICE TREATMENT, REFERRAL OR CO-MANAGEMENT CASES

CONTINUED

1) Patient Age & Initials 2) Vision or Medical Condition 3) In-Office Treatment (T), Referral (R) or Co-management (C) 4) Date of Exam	6	7	8	9	10
Subjective					
Objective					
Assessment					
Plan					

Additional Comments Regarding In-Office Treatment, Referral and/or Co-Management Charts:

General Comments and Practice Impressions of the Reviewer

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Dated this _____ day of _____20_____.

Signed: _____
[Reviewer]

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[Member Being Reviewed]

All areas of the Practice Visit Report must be completed before the member signs this form above.

RECOMMENDATIONS

To be completed by the Competence Committee as a Whole

Name of Practitioner Being Reviewed:

_____

Registration Certificate Number: _____

Upon completion of Parts 1 & 2 of the ACO Practice Visit Report and review of a limited number of patient charts, it is the recommendations of the Competence Committee that:

[ ] Letter #1 - **Satisfactory Review**.

[ ] Letter #2 - **Satisfactory Review -** With minor notations.

[ ] Letter #3 - **Satisfactory Review -** Practitioner will make immediate changes and send written confirmation to the ACO office within 30 days that the specified changes were made.

[ ] Letter #4 - **Unsatisfactory Review –** Practitioner must undergo a 180 day follow up.

[ ] Letter #5 - **Unsatisfactory Review -** Referral to the ACO Complaints Director.

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Practice Visit Comment Form

Comments from the Practitioner Being Reviewed (if so desired).

[This page is to be removed from this package if the practitioner wishes to provide his/her comments after the review has been completed. It must be forwarded to the Alberta College of Optometrists (ACO) office by the practitioner who was reviewed within 10 working days following the date of the practice visit.]

Member to: Fax to: (780) 466-5969
- or-
Mail to: #102, 8407 Argyll Rd., NW, Edmonton, AB T6C 4B2

Name: (please print)
_____

Facility Name, Office Location or Street Address where practice visit took place:
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_____
[postal code]

Date of Practice Visit: _____

Name of Reviewer: _____

COMMENTS

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Signed: Dr. _____

Date: _____