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## Telephone Screening of Ophthalmic Problems:

## Sample Screening Guidelines and Contact Forms

**Anne M. Menke, RN, PhD, OMIC Patient Safety Manager**

**Reviewed by Michelle S. Ying, MD**

**Purpose of risk management recommendations**

OMIC regularly analyzes its claims experience to determine loss prevention measures that our insured ophthalmologists can take to reduce the likelihood of professional liability lawsuits. OMIC policyholders are not required to implement risk management recommendations. Rather, physicians should use their professional judgment in determining the applicability of a given recommendation to their particular patients and practice situation. These loss prevention documents may refer to clinical care guidelines such as the American Academy of Ophthalmology’s *Preferred Practice Patterns*, peer-reviewed articles, or to federal or state laws and regulations. However, our risk management recommendations do not constitute the standard of care nor do they provide legal advice. Consult an attorney if legal advice is desired or needed. Information contained here is not intended to be a modification of the terms and conditions of the OMIC professional and limited office premises liability insurance policy. Please refer to the OMIC policy for these terms and conditions.

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Each day, countless patients call their ophthalmologist to report problems and seek advice. During the day, physicians rely upon their office staff to screen these calls and schedule appointments. After-hours, ophthalmologists themselves field many calls while providing coverage for their own and other physicians’ practices, as well as for the Emergency Departments of hospitals. This recommendation document will provide guidance on how to ensure safe telephone care.

# **1. Patient safety and liability risks of providing care over the telephone.**

During telephone conversations, the health care team does not have access to the wealth of information obtained from face-to-face communication and a physical examination of the patient. Moreover, the patient may be a poor historian who does not know how to communicate what the problem is, or may not want to inconvenience the physician or appear to be whining or complaining. This situation is even more problematic after-hours, when the patient may be unknown to the ophthalmologist and medical records may not be available at the time of the telephone encounter.

Making medical decisions on the basis of the limited information obtained over the telephone is a risky—albeit necessary—aspect of ophthalmic practice. Indeed, OMIC claims experience confirms that inadequate telephone screening, improper decision-making, and lack of documentation all play a significant role in ophthalmic malpractice claims. Negligent telephone screening and treatment of postoperative patients is especially likely to result in malpractice claims.

**RISK REDUCTION MEASURES**

What can ophthalmologists do to promote patient safety and reduce the professional liability risks associated with telephone screening and treatment? First and foremost, exercise the same care when treating a patient over the telephone as you would during an office visit. To promote both the continuity and defensibility of care: 1) gather the information necessary to assess the situation and determine the treatment plan, 2) communicate the assessment and plan to the patient, and 3) document the encounter and your decision-making process in the medical record.

Second, develop written protocols for telephone screening and treatment that are specific to your patient population, subspecialty, and staff. Such protocols will allow your staff to assist you in gathering information and help determine the safest and most efficient way for the patient to receive care. The materials in this document are designed to help you begin that process.

Third, supervise staff members who screen calls. In addition to developing and approving written protocols, the supervision should include: 1) training and verification of competency, 2) willingly answering questions from staff members unsure of how to handle specific calls, 3) regular review of telephone calls (patient’s request, staff answer, physician involvement, etc.), and 4) periodic review of the screening protocols themselves.

**RESPECT SCOPE OF PRACTICE LIMITATIONS WHEN DELEGATING TASKS**

Ophthalmologists are fortunate to employ staff members with detailed knowledge about ophthalmology who have undergone extensive training and certification. These staff members—including ophthalmic assistants, technicians, technologists, and nurses—play an important role in telephone screening.

State laws governing the practice of medicine and patient safety concerns limit the tasks these non-physicians can perform. You and your staff must have a clear understanding of these limits. The role of non-physicians in screening ophthalmic problems consists of gathering information in order to assign an appointment category, not diagnosing or treating a condition or providing medical advice. All medical decisions must be made by you or another ophthalmologist in your practice.

Regardless of their expertise and experience, instruct non-physician staff members not to give patients their opinion about the cause of their symptoms. Train them to say, “Dr. Jones wants to see all patients right away who develop flashes and floaters after surgery,” not “Flashes and floaters can indicate a retinal detachment.”

The same admonition holds true for medical advice: it should only come from you, or at your express direction. If you instruct them to do so, staff members may communicate instructions and information to patients. Provide specific instructions or advice (e.g., “instruct patient to take Advil for the mild ocular pain,” or “instruct patient on how to rinse her eye with sterile saline solution,” etc.). In contrast, a staff member should not independently inform a patient whom she suspects has a retinal detachment to “Stay in bed with your head elevated 30 degrees.”

Instruct staff members not to minimize patient complaints or provide false reassurance. Ask staff to inform you of patients who are concerned about their condition and are not satisfied with the type of appointment given. Juries are not sympathetic when a patient with significant vision loss testifies that she begged the receptionist to be seen right away but was told that nothing serious was wrong.

# **2. Protocol development and staff training**

The telephone contact forms and the call screening guideline provided here are intended as sample templates only. They do not cover all possible patient complaints and may not apply to every situation. Customize them to your practice and (sub) specialty; approve the final, written version; and implement them only after staff training.

Begin the customization process by inviting your staff to review these materials. They can help you identify problems not discussed here, as well as questions, concerns, and any obstacles to implementing them in your practice. Review the protocols regularly to assure that they continue to meet the needs of your patients and practice. Ensure that your protocols address the following issues:

**WHEN TO INTERRUPT THE PHYSICIAN**

* The protocol should indicate if you want to be notified of emergent appointments or other situations, and what to do if the patient requests to speak with you.

**PATIENT’S REQUEST TO BE SEEN SAME DAY/REFERRAL TO ED**

* Ask staff to inform you when a patient’s request to be seen the same day cannot be honored due to scheduling problems. Make every effort to accommodate the patient’s wish.
* If you cannot see the patient when the patient wants to be seen, it is best to speak to the patient personally to understand the cause of the patient’s symptoms and concerns, and determine the appropriate course of action.
* Remind patients of their right to seek emergency care at a hospital if they feel they have an emergency medical condition. Keep in mind, however, that many Emergency Departments may not be equipped to carefully evaluate ophthalmic complaints. Direct the patient to a source of care that is likely to prove beneficial.

**NEW PATIENTS**

* The protocol should indicate whether or not the practice accepts new patients, and how to handle calls from new patients if it does not. For example, instruct staff members to first ask callers if they are a current patient. If the answer is no, ask staff members to inform the caller that the practice does not accept new patients, and to offer callers the name of ophthalmologists in the area who do. Caution staff not to discuss the caller’s condition or complaint if you are not available to treat the caller.

**STAFF QUESTIONS ABOUT SCREENING**

* Staff should be encouraged to consult with you any time questions arise.
* Examples of when to consult with you include complaints that are not listed on the screening guide, those that fall into more than one appointment category, patients with routine complaints who want to be seen the day they call, etc.
* In general, encourage staff members to err on the side of patient safety when consulting with you or assigning an appointment category.

**QUALIFICATIONS**

* It might seem obvious, but authorize only those staff members with the necessary language and communication skills to screen ophthalmic problems over the phone. Such skills include patience, cheerfulness, compassion, clear enunciation, and professionalism, as well as a willingness to abide by the guidelines and seek help whenever needed.
* Take into account the language spoken by the majority of your patients. See [Interpreters for deaf patients](https://www.omic.com/interpreters-for-deaf-patients-recommendations/) and [Interpreters for patients with limited English proficiency](https://www.omic.com/interpreters-for-limited-english-proficiency-patients/) for guidance.

**TRAINING/IMPLEMENTATION OF PROTOCOLS/SUPERVISION**

* Ensure that telephone screening is included as a job responsibility in the employee’s job description.
* Train staff members who handle patient calls, and verify their competency in applying screening guidelines, before allowing them to implement the protocols. Address how supervision will occur.

Once adapted to the individual practice and approved by you, post the guidelines by the phones of all staff members who answer calls. When you update guidelines, note the revision date, and keep a copy of all former versions in case prior care and screening is ever called into question.

# **3. Staff screening and documentation during office hours**

The sample telephone contact form provided here prompts staff members to gather information that will be used to determine the timing of the appointment. The form is designed for ease and speed of documentation by often allowing staff member to circle answers instead of writing them out (you may want to laminate it for use as a guide instead of using a form for each call). Practices with EHRs can scan the form into the record, or ask staff to document the answers in a designated location in the EHR (e.g., “10/1/19, 11:15 am. Mary Smith called to report sudden onset of “flashing lights” and “floating things” OD. Had cataract surgery OD on 8/15/03. Given emergent appointment for today at 1:00 pm. Alex Pogue, receptionist”).

The sample screening guide assigns a category to common visual complaints. Patients with emergent conditions are told to come in or go to the ER immediately. Those with urgent conditions are seen within 24 hours, but you may wish to see these patients the same day. Patients assigned a routine category are given the next available routine appointment. If the patient’s complaints fall into more than one appointment category, always assign the quickest category. For example, if the patient complains of discharge that causes the eyelids to stick together (urgent appointment) and mild ocular irritation, itching, and burning (routine), give the patient an urgent appointment. **If the patient has any complaint that falls into the emergent category, give him/her an emergent appointment and notify the physician.**

Staff members will understandably be concerned about the time required to screen calls using these suggestions. Not every phone call will require asking every question. Rather, the patient’s complaint will determine how many questions should be asked. For example, as soon as enough information is obtained to categorize the appointment as emergent, no more information needs to be obtained, since the patient will be asked to come in immediately. It will, however, take staff members more time and effort to differentiate urgent from routine problems, and may require asking all or nearly all of the questions. **The time spent carefully screening calls is time well spent if it preserves a patient’s vision.**

Be available to respond to staff questions during office hours. Ask staff to inform you when emergent appointments are scheduled, and to inform you if the patient does not keep the appointment. Review calls about emergent or urgent situations daily. Instruct staff not to file/scan forms or finalize the call documentation until you have signed off on them. Review on a regular basis how routine calls are documented. This type of review provides a safety net for patients and documents the supervision of staff. As needed, and as a quality assurance technique, hold staff meetings to address questions and concerns about screening and documentation.

# **4. Handling telephone requests for prescription refills**

Medication errors are the most frequent type of medical misadventure, and can lead to serious patient harm and professional liability. Physicians have a duty to monitor the continued need, effectiveness, and safety of the drugs they prescribe. To fulfill this duty, they need to examine patients on a regular basis. Many states have “good faith prior examination” laws that stipulate the maximum time drugs can be prescribed without another examination. To effectively monitor the safety of medications and comply with good faith examination requirements, prescription refill requests need to be handled with care.

**RESPECT SCOPE OF PRACTICE LAWS**

* You and your staff need to understand the difference between authorizing a refill (issuing a drug order again) and transmitting a refill order to the pharmacy. While many members of the healthcare team may be assigned the task of calling or faxing the pharmacy with a refill order, or entering an oral order into the CPOE (computerized physician order entry) system, only healthcare providers with the legal authority to order drugs can authorize prescription refills. In most ophthalmology practices, only ophthalmologists can do so.

**COMMUNICATE YOUR REFILL POLICIES TO YOUR PATIENTS**

* Some practices do not accept after-hours requests. Others instruct patients to call the pharmacy for the refill; the pharmacy then faxes over a request that includes the prescribing information. This system cuts down on the errors that can be introduced from poor handwriting or when transmitting verbal orders, and can provide you with the patient’s medication use history if desired.

**PATIENTS WITH CHRONIC CONDITIONS**

* Tell patients who are on medications for chronic conditions that they will only be given enough medication to last until the next required follow-up visit. Instruct them to schedule their next visit before their medication runs out. You can also cut down on refill requests by routinely asking patients during visits if they need prescriptions.

**SAMPLE REFILL PROTOCOL**

* Carefully document the number of refills you authorize before the patient must return for a follow-up appointment (e.g., “Continue Timoptic drops until follow-up appointment in three months”).
* When a patient or pharmacy calls the office to obtain a prescription refill, instruct your staff to first verify whether you have authorized the refill. They can do so by checking either the Medication Summary Sheet or the Progress Notes, depending upon the protocol for documenting drug orders and refills in your practice.
* If the refill request raises concerns or there is no refill authorization in the chart, direct your staff to give you the refill request (and the patient’s chart if you have paper records).
	+ Indicate whether or not the refill is authorized, then date and sign your response.
	+ Note the reason for a denial, and ask staff to contact any patient whose refill request is denied. You might want to develop a chart stamp or a drop-down choice with the possible reasons, which you can then indicate (e.g., “Tell patient I am required by law to evaluate him once a year in order to prescribe medications” or “Tell patient I need to see her every X months to evaluate her condition and the safety and effectiveness of the medication.)”.
	+ Ask the staff member who contacts the patient to record the date and time of the call and of the scheduled appointment.

# **5. Screening and documentation of after-hours calls**

OMIC claims experience includes multiple cases where the ophthalmologist’s only involvement in a patient’s care was an undocumented after-hours contact or prescription refill. The [After-hours/On-call contact form](#_After-hours/On-call_telephone_conta) prompts you to ask about recent procedures or surgeries, and whether the patient has contacted other healthcare providers about the same or related problems. Compact “Patient Care Phone Call Records” can also be obtained from OMIC; these call record pads can be kept in your car, purse, briefcase, or locker.

Once you return to the office, place or tape the contact form in your patient’s medical record, or scan it into your EHR. If you are providing on-call coverage for a physician in another practice, tell the physician about your contact with the patient when you go off-call, and fax a copy of the contact form and other records; retain the original in a file designated “On-call coverage contacts.”

Protocols and forms for providing telephone care can help ensure that patients obtain care in a timely manner, and that the care is documented in the medical record. These protocols can also ensure a more efficient refill process.

**OMIC policyholders who have additional questions or concerns about telephone care are invited to use OMIC’s confidential Risk Management Hotline by emailing us at** **riskmanagement@omic.com****, or calling 800-562-6642, option 4.**

**Patient Telephone Screening Form**

Name of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient of Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ New patient? Yes/No

Time of call \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of call \_\_\_\_\_\_\_\_ New referral from Dr.\_\_­­\_\_\_\_\_\_\_\_\_\_\_

Name of staff member taking call \_\_\_\_\_\_\_\_\_\_\_\_\_\_

* What is your problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* When did your problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How suddenly did it begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Has the problem worsened, improved, or remained unchanged?
* Does it affect one eye or both? If one eye, which one? Right/Left
* Have you recently had surgery or a procedure? Yes/No
	+ Type and date of surgery/procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Has your vision changed? Yes/No
	+ Loss of vision? Yes/No Constant/Intermittent
		- If yes, describe loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Flashes? Yes/No Floaters? Yes/No Shadows in peripheral vision? Yes/No
	+ Change in vision? Yes/No. (circle one and choose type)
		- Double vision? Distorted vision? Fading vision? Other:\_\_\_\_\_\_\_
* Eye pain? Yes/No Location, description, intensity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Has the pain worsened, improved, or remained unchanged?
	+ Did nausea and vomiting accompany the pain? Yes/No
	+ Is there any other type of pain? Yes/No
		- Headache Facial pain Jaw pain or ache Other: \_\_\_\_\_\_\_\_\_\_\_\_
* Are your eyes red? Yes/No
	+ Has redness worsened, improved, or remained unchanged?
* Discharge from the eye? Yes/No. If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Eyelids stick together? Yes/No.
* Any burn/injury to the eye, forehead, or face? Yes/No
	+ Eyelid damaged? Yes/No Pain? Yes/No Vision loss? Yes/No
	+ Describe how burn/injury occurred\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* Do you wear contact lens? Yes/No Glasses? Yes/No
* Any other problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of appointment: Emergent Urgent Routine

Date and time of appointment:

Ophthalmologist’s advice or instruction:

**TELEPHONE SCREENING OF OPHTHALMIC PROBLEMS GUIDE
Assign category after completing telephone contact form**

|  |  |  |  |
| --- | --- | --- | --- |
| **COMPLAINT** | **EMERGENT** | **URGENT** | **ROUTINE** |
|  | Requires immediate action Advise patient to come to office or go to ER immediately.Notify physician. | See patient within 24 hoursConsult with ophthalmologist if in doubt.Err on side of safety. | Schedule next available routine appointment time Tell patient to call back if symptoms worsen or vision becomes impaired before appointment. |
| **VISION LOSS** | Sudden, painless, severe loss of vision | Subacute loss of vision that has evolved gradually over a period of a few days to a weekAsk if vision loss is persistent (constant) or intermittent (off and on) |  |
|  | Loss of vision after surgery or procedure |  |  |
| **VISION CHANGES** | Vision changes after surgery or procedure | Sudden onset of diplopia (double vision) or other distorted vision | Difficulty with near or distance work, or fine print |
|  |  | Double vision that has persisted for less than a week |  |
| **PAIN** | Acute, rapid onset of eye pain or discomfort | Mild ocular pain if accompanied by redness and/or decrease in vision | Discomfort after prolonged use of the eyes |
|  | Progressively worsening ocular pain |  |  |
|  | Worsening pain after surgery or procedure |  |  |
| **COMPLAINT** | **EMERGENT** | **URGENT** | **ROUTINE** |
| **FLASHES/****FLOATERS** | Recent onset of light flashes and floaters in patient with: * Significant myopia (nearsightedness): ask about history of LASIK or refractive surgery
* After surgery or procedure, or
* Accompanied by shadows in the peripheral vision.
 | Recent onset of light flashes and floaters without symptoms of emergent categoryMany ophthalmologists prefer to see these patients the same day. If in doubt, consult with the ophthalmologist.  | Persistent and unchanged floaters whose cause has been previously determined |
| **REDNESS/** **DISCHARGE** | Worsening redness or discharge after surgery or procedure. | Acute red eye, with or without discharge | Mucous discharge from the eye that does not cause the eyelids to stick together |
|  | Redness or discharge in a contact lens wearer | Discharge or tearing that causes the eyelids to stick together. | Mild redness of the eye not accompanied by other symptoms |
| **OTHER EYE COMPLAINTS** |  | Photophobia (sensitivity to light) if accompanied by redness and/or decrease in vision | Photophobia as only symptom  |
|  |  |  | Mild ocular irritation, itching, burning |
|  |  |  | Tearing in the absence of other symptoms |
| **BURN** | Chemical burns: alkali, acid, organic solvents.Give instructions on how to treat burns. |  |  |
| **COMPLAINT** | **EMERGENT** | **URGENT** | **ROUTINE** |
| **FOREIGN BODY** | A foreign body in the eye or a corneal abrasion caused by a foreign body |  |  |
| **TRAUMA****(INJURY)** | Trauma in which the globe (eyeball) or eyelid has been or is likely to be disrupted or penetrated | Blunt trauma, such as a bump to the eye, that is not associated with vision loss or persistent pain and where penetration of the globe (eyeball) is not likely. |  |
|  | Any trauma that is associated with visual loss or persistent pain |  |  |
|  | Severe blunt trauma, such as a forceful blow to the eye with a fist or high-velocity object such as a tennis ball or racquet ball |  |  |
| OTHER | Any emergency referral from another physician  | Loss or breakage of glasses or contact lens needed for work, driving, or studies. (Check with doctor to see if considered urgent or routine.) |  |

**After-hours/On-call Telephone Contact**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/time of call:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary M.D.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has complaint persisted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Related symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent tests/procedures/surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Previous phone calls or visits to other healthcare professionals about this or related complaints: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other significant ocular/medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Advice or instructions given/treatment or medication ordered \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Follow-up plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Above information provided to primary M.D. (M.D. who is being covered):

M.D. name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date/time information communicated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On-call M.D. signature/initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_