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## After-Hours Screening of Ophthalmic Problems

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**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.

**Version 5/9/19**

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 telephone screening toolkit will provide guidance on how to ensure safe telephone care.

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 contact form](https://www.omic.com/after-hours-contact-form-and-recommendations/) 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. If you are providing on-call coverage for a physician in another practice, tell the physician 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 and title 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 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
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 burn instructions. |  |  |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_