OREGON BOARD OF OPTOMETRY

OPTOMETRIST'S RESPONSE TO INVESTIGATION

1. Name of Optometrist _____

   Address _____ Phone _____
   Street City

2. Name of Patient _____

3. Date of original examination/office visit relating to this inquiry _____

4. Chief visual complaint at that time _____

5. Diagnosis _____

   _____

6. Therapy prescribed (please circle) a. Prescription lenses (glasses) b. Contact lenses c. Visual training d. Low vision aids e. If none of these were prescribed, what was the outcome of the examination? _____

   _____

7. Entrance Rx

	Sph	Cyl	Axis	Δ	Bse	Add	Bs Cv	+ - Cyl	Tint	Plastic	Aided Acuity far	near
OD										Glass	20/	20/
OS										Temper	20/	20/

Seg Style	Ht.	O.C.	Special Items
Frame			
Eye	Bridge	Tpl	

8. New Rx

	Sph	Cyl	Axis	Δ	Bse	Add	Bs Cv	+ - Cyl	Tint	Plastic	Aided Acuity far	near
OD										Glass	20/	20/
OS										Temper	20/	20/

Seg style	Ht.	O.C.	Special Items
Frame			
Eye	Bridge	Tpl	

9. Did you recommend the patient consult:

   a. another optometrist? (yes) (no) Specialty_____

   b. a physician? (yes) (no) Specialty_____

   Patient (followed) (did not follow) instructions relative to consultation.

   Response (was) (was not) received from consultant.

10. What other advice or instructions did you give this patient?_____

    _____

11. Has this patient contacted you expressing dissatisfaction with the professional care rendered? (yes) (no) date/s of contact_____

12. Nature of the dissatisfaction:_____

    _____

13. Describe any remedial action taken by you:_____

    _____

14. Patients response to the remedial action:_____

    _____

15. What fees did you charge for those services under evaluation? (Attach copies)

Date	Professional Services	Materials

16. Please attach the copies of the following:

    a. Clinical findings (including case history and advice given) for every visit the patient made to your office. Include any and all visits even if they were prior to the time of the dissatisfaction being evaluated.
    b. Any correspondence from the patient relative to this problem.
    c. Any consultants reports.

17. Supply a narrative response to any of the above items needing further explanation.

_____ _____

Signed Date

Certification of Patient Records

OREGON BOARD OF OPTOMETRY

To the Oregon Board of Optometry:

I certify that, unless otherwise specifically indicated, the attached patient file information contains complete patient records for each of the patients identified in the Oregon Board of Optometry's request, including, but not limited to:

- Examination forms
- Patient history forms
- Prescriptions
- Chart notes
- Billing records
- Correspondence
- Personal office notes
- Other reports, and
- Any and all other relevant information.

I understand that I am personally responsible for the accuracy and completeness of this information.

Printed name: _____ , OD

Signature: _____, OD Date: _____

Send this form and all required materials to:

Oregon Board of Optometry
1500 Liberty Street SE, Suite 210
Salem, Oregon 97302-1338
Fax: 503-914-5142
Email: Optometry.Board@oregon.gov