OPTICAL COMPLAINT CHECK-OFF LIST

Date_____ Date patient received the glasses_____

Yes No

[] [] 1. Lens prescription correct, according to RX in chart.

[] [] 2. Is there unwanted prism?

[] [] 3. Frame adjusted?

[] [] 4. Bifocal, Trifocal or progressive seg height correct?

[] [] 5. Pd correct Far, Near?

[] [] 6. Base curves checked?

[] [] 7. Material difference, if so explain to patient why material was changed.
. (Was this the patients choice) yes____ NO_____

[] [] 8. Is patient having difficulty with distance RX?

[] [] 9. Is patient having difficulty with near RX?

[] [] 10. Is patient having trouble with double vision?

[] [] 11. Check vision with and without glasses. Is corrected vision what DR measured.

With any prescription change, the patient has to take the glasses home, if all items above are correct, please try to adapt to the new RX for at least 2 weeks. Please explain to the patient that it's in their best interest to give the new glasses a chance. If after trying to wear them the patient is still having difficulty please have them schedule an appointment with the same doctor that prescribed them.

***** SCAN THIS INTO THE EHR AFTER COMPLETION. *****

Chart#_____ Optician_____