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I have read and am familiar with the contents of the UHCO Residency Program Manual.

_________________________________________  _____________
Signature                                           Date

Return this page to Ashley Olheiser no later than July 2, 2015
Brain Injury Vision Rehabilitation Residency

Mission Statement:
The residency program in Brain Injury Vision Rehabilitation (BIVR) seeks to attract highly qualified optometric graduates and to provide them with advanced knowledge and concentrated clinical experience in all aspects of brain injury rehabilitation including: the vision care of patients with neuro-degenerative disease, patients recovering from traumatic or other acquired brain injury, and patients with other special needs; the evaluation, management, and co-management of binocular vision anomalies; the evaluation and management of multiply-challenged patients of all ages; and the evaluation and management of patients in need of low vision rehabilitation. Residents who complete the program are expected to provide an advanced level of clinical care in neuro-optometric rehabilitation.

Goals and Objectives:
Goal 1: To attract and select highly qualified candidates and provide them with faculty and administrative support.

Objectives:
1. Make optometry students aware of the program at the University of Houston and encourage application by highly qualified candidates.
2. All interviewed candidates must have complete applications and meet all academic criteria for the residency.
3. An office, computer, technical support, email, Internet access, and library access will be provided for the resident.
4. An examination room will be provided and state of the art clinical equipment will be available.
5. Consultation with clinical faculty will be available at all times the resident is involved in patient care.

Goal 2: To provide formal and informal opportunities in the resident’s curriculum to obtain advanced knowledge in all aspects of neuro-optometric rehabilitation and other optometric fields including an emphasis on acquisition of the best available scientific evidence.

Objectives:
1. The resident will participate in a didactic curriculum including: resident journal club, resident case discussions, grand rounds, and continuing education lectures.
2. The resident will analyze the best available scientific clinical evidence in neuro-optometric rehabilitation and related fields from the current literature and through attendance at scientific meetings.
3. The resident will present a minimum of forty cases to the Neuro-Optometric Rehabilitation Residency Program Coordinator for critique of evidence-based patient care.
4. The resident will be assigned four hours of development time each week.

Goal 3: To obtain advanced clinical skills and experience in neuro-optometric rehabilitation and related fields.

Objectives:
1. Clinical assignments will fulfill the core clinic curriculum which is designed to provide experiences leading to advanced clinical competency.
2. A minimum of 600 patient encounters will be provided to the resident.
3. The resident will continuously improve patient care through assessment and quality assurance.
4. The resident will integrate their knowledge of scientific clinical evidence with their clinical expertise in the care of patients.

5. The resident will demonstrate advanced clinical competency in the evaluation, diagnosis, and management of ocular and visual anomalies in patients of all ages (infant – geriatric) with acquired brain injury and neurologic disease.

6. The resident will demonstrate advanced clinical competency in the evaluation, diagnosis, and management of non-strabismic binocular vision and accommodative disorders.

7. The resident will demonstrate advanced clinical competency in the evaluation, diagnosis, and management of strabismus.

8. The resident will demonstrate advanced clinical competency in the evaluation, diagnosis, and management of children with special needs (i.e. Down syndrome, autism, cerebral palsy).

9. The resident will demonstrate advanced clinical competency in the evaluation, diagnosis, and management of patients in need of low vision rehabilitation.

Goal 4: To enhance communication skills with patients and professionals.

Objectives:

1. The resident will provide patient-centered care through patient education, communication, and shared decision making.

2. The resident will communicate effectively with optometrists, physiatrists, rehabilitation therapists, other health care providers, and professionals outside of the health care field to enhance coordination of care.

3. The resident will develop the ability to promote and disseminate knowledge through scholarly activities such as lectures, presentations, publications, posters, and/or research.
Ocular Disease at Cedar Springs

Program Mission Statement: The Ocular Disease Residency Program at Cedar Springs Eye Clinic is a one-year post-doctoral, clinical training program in the diagnosis and management of ocular disease and ocular manifestations of systemic disease. The residency provides advanced competency in knowledge and clinical skills through a scholarly, didactic, and clinical curriculum to highly qualified optometric graduates. Residents completing the program are expected to provide an advanced level of clinical care in ocular disease.

**Goal 1:** To attract and select highly qualified residency candidates.

**Objectives:**
1. Encourage applications from highly qualified candidates at the UHCO
2. Advertise residency position to students at other schools and colleges of optometry
3. Interview candidates with complete applications that meet all academic criteria for the residency.

**Goal 2:** To provide an advanced level of clinical training in ocular disease and ocular manifestations of systemic disorders.

**Objectives:**
1. Provide a minimum of 1500 patient encounters with more than 50% of encounters involving an ocular or systemic disease related diagnosis.
2. Develop advanced skills in testing and interpretation using specialized diagnostic instrumentation.
3. Enhance the ability to formulate appropriate ocular differential diagnoses, implement treatment plans and manage a variety of ocular diseases and ocular manifestations of systemic disorders.
4. Enhance understanding of the roles of other health care providers.
5. Enhance competence in communication with health care providers.
6. Enhance competence in patient education and communication.

**Goal 3:** To provide formal and informal opportunities to obtain advanced knowledge in ocular disease management and ocular manifestations of systemic disorders through didactic and scholarly activities and resources.

**Objectives:**
1. Provide advanced clinical knowledge through didactic programs and electronic scholastic resources.
2. Enhance critical thinking and evidence-based clinical decision making.
Mission Statement:
The residency program in Cornea and Contact Lens seeks to attract highly qualified optometric graduates and to provide them with advanced knowledge and concentrated clinical experience in all aspects of fitting and management of contact lens patients. Residents who complete the program are expected to provide an advanced level of clinical care in cornea and contact lenses, serve as educators and researchers in academic settings and/or serve the profession of optometry as experts and leaders in the area of cornea and contact lenses.

Goals and Objectives:

**Goal 1: To attract and select highly qualified candidates.**
Objective 1. Encourage applications by highly qualified candidates identified by the University of Houston College of Optometry Contact Lens Faculty.

Objective 2. Provide residency information to students at other Schools and Colleges of Optometry.

Objective 3. All interviewed candidates must have complete applications and meet all academic criteria for the residency.

**Goal 2: To provide space, faculty and administrative support to the program.**
Objective 1. An office/examination room with state of the art equipment will be provided for the resident.

Objective 2. Use of the libraries at the College, University of Houston, and the Texas Medical Center will be available to the resident.

Objective 3. Benefits and funding for travel to an approved optometric meeting will be provided.

**Goal 3: To provide formal and informal opportunities in the resident’s curriculum to obtain advanced knowledge in all aspects of cornea and contact lenses through didactic and scholarly activities and resources.**
Objective 1. The resident will present a minimum of forty cases to the Cornea and Contact Lens Residency Director for critique of patient care and discussion.

Objective 2. The resident will attend a minimum of twenty educational seminars of which at least three will cover cornea and/or contact lens topics.

Objective 3. Four hours of development time will be scheduled for the resident each week.

**Goal 4: To obtain advanced clinical experience in all aspects of contact lenses.**
Objective 1. The resident will participate in a minimum of 300 sessions (half day) of the UEI Cornea and Contact Lens Service. It is expected that 50% of the patients seen will be complex or highly complex fitting challenges.

Objective 2. In order to enhance encounters with ocular disease, the resident will rotate through clinical sites that have a high percentage of patients with ocular disease.

Objective 3. The resident will effectively communicate verbally and/or in writing with optometrists and/or other health care providers or professionals to assure appropriate care of the patient.

**Goal 5: To increase the resident’s knowledge about the research process and critical reading of research literature.**
Objective 1. The resident will make three oral presentations during Clinical Rounds.
Objective 2. The resident will complete a manuscript of publishable quality based on original or library research.
Objective 3. The resident will make oral and/or poster presentations to optometrists or optometry students.
Objective 4. The resident will be required to complete 16 hours of continuing education credits as outlined in the curriculum. Funding and leave will be provided to attend approved optometric meetings.

Goal 6: To prepare residents to provide an advanced level of clinical care in cornea and contact lenses, serve as educators and researchers in academic settings and/or serve the profession of optometry as experts and leaders in the area of cornea and contact lenses.
Objective 1. The resident will serve as a clinical attending and/or laboratory teaching assistant in the supervision of optometry students.
Objective 2. Former residents are expected to devote a significant portion of patient care activities to cornea and contact lenses and/or serve as faculty or adjunct faculty at schools and colleges of optometry. They will be encouraged to publish papers, present research findings at scientific meetings, and/or provided optometric continuing education and to obtain fellowship in the American Academy of Optometry and/or hold membership in the American Optometric Association or other professional organizations.
Family Practice Residency

Mission
The Family Practice Optometry Residency Program at the University of Houston seeks to attract highly qualified optometric graduates and to provide them with a one-year post-doctoral, clinical training program designed to provide advanced knowledge and concentrated clinical experiences as well as promote scholarly development. Residents who complete the program are expected to attain advanced clinical competencies in a variety of aspects of optometric care including contact lens, low vision, pediatrics and binocular vision, and treatment and management of ocular disease.

Goal 1: To attract and select highly qualified candidates.

Objectives:
1) Inform optometry students of the program at the University of Houston and encourage application by highly qualified candidates.
2) All interviewed candidates must have complete applications and meet all academic criteria with preference given to candidates with a GPA of at least a 3.0 out of 4.0.

Goal 2: To provide faculty and administrative support to the resident.

Objectives:
1) An examination room/office with state of the art clinical equipment will be provided as well as a computer, technical support, email, internet access, and access to the University of Houston and the Texas Medical Center library.
2) Consultation with clinical faculty will be available at all times the resident is involved with patient care.
3) Benefits (i.e., medical, retirement) and funding for travel to an approved optometric meeting will be provided.

Goal 3: To provide formal and informal opportunities in the residents' curriculum to obtain advanced knowledge in all aspects of optometry.

Objectives:
1) The resident will participate in a didactic curriculum including Resident Journal Club, Resident Case Discussion, Clinical Rounds, workshops and continuing education lectures.
2) Development time will be provided to the resident.

Goal 4: To prepare the resident to provide an advanced level of care through broad, concentrated clinical experiences encompassing the diagnosis, treatment and management of all aspects of optometry.

Objectives:
1) To provide the resident a minimum of 800 patient encounters throughout the year. The patient population will consist of all age groups from pediatric through geriatric and a diversity of ethnicity.
2) Clinical assignments will fulfill the core curriculum requirements. The residents schedule will be designed to provide a diverse experience in the diagnosis and management of ocular conditions likely to be found in a primary care setting. This training will lead to advanced clinical competency.
3) The resident will develop advanced knowledge and clinical expertise in all aspects of optometry.
Goal 5: To enhance the residents written and oral communication skills with optometrists, health care providers and other professionals.
Objectives:
1) The resident will write a minimum of 10 letters to optometrists, other health care providers, or professionals outside the health care field.
2) The resident will give a minimum of 4 presentations to optometrists or optometry students.

Goal 6: To increase the resident’s knowledge about the research process and critical reading of research literature.

Objectives:
1) The resident will participate regularly in Resident Journal Club and will facilitate discussion of at least 1 research paper.
2) The resident will complete a manuscript of publishable quality based on original or library research.
3) The resident will be required to submit at least 1 abstract to an optometric meeting.
4) The resident must attend at least one approved optometric meeting with a scientific component.

Goal 7: To prepare residents to serve as educators and/or researchers in the profession of optometry or as experts in the area of primary care.

Objectives:
1) The resident will gain teaching experience by serving as a clinical attending or teaching assistant in the optometric curriculum.
2) Encourage residents to serve as faculty or adjunct faculty at Schools and Colleges of Optometry; to publish a paper or original research, present clinical education at a national or international optometric meeting; and to obtain fellowship in the American Academy of Optometry.
Low Vision Rehabilitation Residency
Mission Statement: The residency program in Low Vision Rehabilitation seeks to attract highly qualified optometric graduates, and to provide them with advanced knowledge and skills in all aspects of low vision rehabilitation. The residency involves the management of patients with visual impairment including central field loss, acquired neurological disorders, traumatic brain injury, ocular prosthetics, specialty contact lenses, and other adaptive or assistive technology. Residents who complete the program are expected to provide an advanced level of clinical care in low vision rehabilitation.

Goal 1: To attract and select highly qualified candidates

Objectives
1. Encourage applications from highly qualified candidates identified by faculty at the University of Houston, College of Optometry.
2. Encourage applications from highly qualified candidates identified by faculty or contacts at other schools and colleges of optometry.
3. Advertise residency in a national optometric publication.
4. Publicize residency at a minimum of two national optometric meetings per year.
5. All interviewed candidates must have complete applications and meet all academic criteria for the residency.

Goal 2: To provide formal and informal opportunities in the resident’s curriculum to obtain advanced knowledge in low vision rehabilitation and other fields of optometry through didactic and scholarly activities.

Objectives
1. The resident will present a minimum of 8 cases illustrating advanced competencies in low vision patient care.
2. The resident will meet regularly with the program director to discuss cases, assigned readings, and current journal articles.
3. The resident will meet with attending faculty to discuss clinic cases at least weekly.
4. The resident will attend low vision faculty meetings.
5. The resident will attend the Residents’ Journal Club and Case Discussion, Clinical Periopsias, Resident Seminars and Harris County Optometric Society (HCOS) or other continuing education meetings as outlined. The resident is required to attend a minimum of 16 hours continuing education.
6. The resident will complete a manuscript of publishable quality based on original or library research.

Goal 3: To obtain advanced clinical experiences in all aspects of low vision rehabilitation

Objectives
1. The resident will participate in a minimum of 4 days per week of patient care with a minimum of 3 days in low vision patient care settings.
2. The resident will participate and demonstrate competency in direct patient care with a minimum of 75% of patient encounters at the advanced to highly advanced level of diagnosis and/or management (defined by the clinic curriculum) in low vision settings.
3. The resident will demonstrate competence in patient education and communication.
4. The resident will interact with and demonstrate competence in written and oral communication with optometrists, ophthalmologists, other healthcare providers, and other allied professionals.
Ocular Disease Residency at UEI

Mission Statement: The Ocular Disease Residency Program at the University of Houston College of Optometry (UHCO) is a one-year post-doctoral clinical training program in the diagnosis and management of ocular disease. The residency provides advanced competency in knowledge and clinical skills through a scholarly, didactic, and clinical curriculum to highly qualified optometry graduates. Residents completing the program are expected to provide an advanced level of clinical care in ocular disease.

Goal 1: To attract and select highly qualified residency candidates.
Objectives:
1. Encourage applications from highly qualified candidates at the UHCO
2. Advertise residency position to students at other schools and college of optometry.

Goal 2: To provide an advanced level of clinical training in ocular disease.
Objectives:
1. Provide a minimum of 1000 patient encounters, at least 75% of which involve an ocular or systemic disease as the primary diagnosis.
2. Develop advanced skills in testing and interpretation using specialized diagnostic instrumentation.
3. Enhance the ability to formulate appropriate differential diagnoses, implement treatment plans, and manage a variety of ocular disorders.
4. Enhance understanding of the roles of other health care providers.
5. Enhance competence in communication with health care providers.
6. Enhance competence in patient education and communication

Goal 3: To provide formal and informal opportunities to obtain advanced knowledge in ocular disease management through didactic and scholarly activities and resources.
Objectives:
1. Provide advanced clinical knowledge through didactic programs and electronic scholastic resources.
2. Provide advanced clinical knowledge through scholarly activities.
3. Enhance critical thinking and evidence-based clinical decision making.
Pediatric Optometry Residency

Mission Statement:
The residency program in Pediatric Optometry seeks to attract highly qualified optometric graduates and to provide them with advanced knowledge and concentrated clinical experience in all aspects of pediatric optometry including: the routine vision care of infants and preschool children; the evaluation, management, and co-management of binocular vision anomalies; the evaluation and management of multiply-challenged children, children with learning difficulties and developmental disorders, as well as patients with acquired brain injuries. Residents who complete the program are expected to provide an advanced level of clinical care in pediatric optometry.

Goals and Objectives:

Goal 1: To attract and select highly qualified candidates and provide them with faculty and administrative support.

Objectives:
1. Make optometry students aware of the program at the University of Houston and encourage application by highly qualified candidates.
2. All interviewed candidates must have complete applications and meet all academic criteria for the residency.
3. An office, computer, technical support, email, Internet access, and library access to the University of Houston, College of Optometry and the Texas Medical Center will be provided for the resident.
4. An examination room, for use only by the resident, will be provided and state of the art clinical equipment will be available.
5. Consultation with clinical faculty will be available at all times the resident is involved in patient care.

Goal 2: To provide formal and informal opportunities in the resident’s curriculum to obtain advanced knowledge in all aspects of pediatric optometry and other optometric fields.

Objectives:
1. The resident will participate in a didactic curriculum including: resident journal club, pediatric journal club, resident case discussions, clinical rounds, and continuing education lectures.
2. The resident will present a minimum of forty cases to the Pediatric Optometry Residency Coordinator for critique of patient care and discussion.
3. Four hours of development time will be scheduled for the resident each week.

Goal 3: To obtain advanced clinical skills and experience in all aspects of pediatric optometry.

Objectives:
1. Clinical assignments will fulfill the core clinic curriculum requirements which are designed to provide experiences leading to advanced clinical competency.
2. A minimum of 800 patient encounters will be provided to the resident.
3. The resident will continuously improve patient care through self-assessment and quality assurance.
4. The resident will develop knowledge and clinical expertise in pediatric development (non-visual and visual) and procedures necessary for advanced competency in the evaluation, diagnosis, and management of ocular and visual anomalies in infants, preschoolers, and school age children.
5. The resident will develop knowledge and clinical expertise necessary for advanced competency in the evaluation, diagnosis, and management of non-strabismic binocular vision and accommodative disorders.
6. The resident will develop knowledge and diagnostic clinical expertise necessary for advanced competency in the evaluation, diagnosis, and management of strabismus and amblyopia.
7. The resident will develop knowledge and clinical expertise necessary for advanced competency in the evaluation, diagnosis, and management of visual perceptual skills and other vision learning-related disorders.
8. The resident will develop knowledge and clinical expertise necessary for advanced competency in the evaluation, diagnosis, and management of children with special needs (i.e. Down syndrome, autism, cerebral palsy).
9. The resident will develop knowledge and clinical expertise necessary for advanced competency in the evaluation, diagnosis, and management of children and adults with acquired brain injuries and neurological diseases.

**Goal 4:** To enhance communication skills with patients and professionals to assure that appropriate resources are utilized for well-coordinated patient care.

**Objectives:**
1. The resident will develop the ability to provide patient-centered care for those with complex conditions through patient education, communication, and shared decision making.
2. The resident will develop the ability to communicate effectively in writing with optometrists, other health care providers, and professionals outside of the health care field.
3. The resident will develop the ability to promote and disseminate knowledge through scholarly activities such as lectures, presentations, publications, posters, and/or research.

**Goal 5:** The resident will master interpretation and utilization of scientific literature for evidence-based clinical decision making.

**Objectives:**
1. The resident will learn to review, discuss, analyze and apply landmark articles, major clinical trials, and other scientific literature in order to apply evidenced-based literature to patient care.
2. Funding and leave for travel to an approved optometric meeting with a scientific component (i.e. AAO, AOA) will be provided.
GETTING STARTED

1. University Orientation. Residents must attend New Employee Orientation provided by the University. This orientation includes:
   a. employee sign-up paperwork
   b. benefits information and sign-up
   c. training for sexual harassment compliance, equal employment opportunity, and hazardous communications
   d. Cougar One Card (employee ID)
   e. parking permit

2. Optometry Business Office
   a. Keys - Keys for your office and clinic area have been ordered for you. You will need to pick the keys up at Key Control in the lobby of the General Services Bldg. (GEN building #585) Your Cougar One Card will serve as access to the building after hours (through HBSB)
   b. Copy Codes - Copy codes, which may be used in the faculty mail room and Optometry Library for work related copying, are available in the Business Office.

3. Leave Procedure
   Leave is entered by logging into PASS and approved by Dr. Fern. Additional procedures are necessary for both sick leave and vacation requests – see Section 2, pages 3 to 4.

4. Library Access
   Bring your Cougar One Card to library orientation. The Optometry Library activates your library privileges. Access to E journals, electronic databases and interlibrary loan is discussed during the library orientation. See Suzanne Ferimer, head optometry librarian, for questions.

5. On-call Service
   a) A mobile phone is used for on-call and is shared by residents. It is a “pay as you go” phone – notify Carl Branch (email or X31886) if fewer than 45 minutes are available or the phone malfunctions.
   b) All other questions – contact Dr. Lambreghts (X31975).

5. Clinic Coats - Coats is provided at orientation. You are responsible for cleaning and pressing of the coat.

6. Office Supplies - Available in the Equipment Room on the first floor.

7. CPR Certification - Residents are required to hold a current CPR certificate with expiration June 30, 2016 or later. CPR certification will be conducted during orientation.

8. Computer problems with your non-EMR computer– email OPT-IT-Support@uh.edu or if unable to email, contact Darrin Nguyen (X31403). For immediate assistance with your EMR computer, talk to the Service Coordinator. They will contact IT to provide assistance. To set up your CougarNet password, follow instructions provided at University orientation.

9. Parking – residents are required to purchase a parking pass. Residents may NOT park in the patient parking lot. The exception is the Family Practice resident at GNC as this resident is at the College only one-half to one-day per week.

8. Resident Manual - Read the resident manual, sign and return the page immediately following the title page to Ashley Olheiser in Office of Student Affairs no later than July 1.
RESIDENT RESPONSIBILITIES

Residents are expected to:

1) Develop a personal program of self-study and professional growth with guidance from your Program Coordinator.

2) Acquire appropriate skills at each level of training, and exercise sound clinical judgment.

3) Participate in safe, effective, and compassionate patient care under supervision, commensurate with their level of advancement and responsibility, carrying an appropriate patient load.

4) Perform, in a professional manner, the delivery of patient care services and to observe the conduct and courtesies that are consistent with the rules and regulations governing the University Eye Institute.

5) Be available for patient care including On-Call Service at all assigned times.

6) Participate fully in the didactic and scholarly activities of their program.

7) Participate in institutional programs and activities involving the medical and optometric staff and adhere to established practices, procedures, and policies of various institutions.
CRITERIA FOR COMPLETION OF RESIDENCY

1. The resident is required to deliver clinical services at a level, which demonstrates they have attained the core competencies specific to their program. This attainment will be determined through formal evaluations of the resident’s patient care.  
   Review the Mission, goals and objectives specific to your program (see section 1), program evaluations (section 4), supervision policy and clinical practice guidelines (section 2).

2. The resident is required to keep a log of patient names and associated information.  
   See section 2. Specifics of the log and the template will be provided by your Residency Program Coordinator during program specific orientation.

3. The resident must complete the scholarly project requirements specific to their program. This is either original or library research resulting in a paper of publishable quality.**  
   See research deadlines in section 2.

4. The resident is required to deliver three presentations in the Clinical Rounds Course.**  
   Low Vision Rehabilitation Residency has additional requirements that will be discussed during the program specific orientation.

5. The resident is required to successfully complete all clinical rotations included in the Core and Elective curriculum.  
   Section 1.

6. The resident is required to successfully complete all teaching assignments.  
   Section 1.

7. The resident must attend required seminars, journal clubs and case discussions.  
   Review Didactic Activities in section 2.**  
   Pediatric Optometry Resident participates in the Pediatrics/Binocular Vision Journal Club

8. The resident must complete all required evaluations of clinical attendings, rotations, seminars, their Program Coordinator, and the exit interview.  
   Section 4.

9. The Director of Residency Programs in conjunction with the Program Coordinator will recommend the granting and certification to the Dean. Upon completing all requirements of the program to the satisfaction of the Program Coordinator and Director of the Residency Programs, a certificate of completion will be awarded to the resident.

**Cedar Springs Ocular Disease Residency has different requirements in these areas:  
Scholarship:  
   1. The Resident is required to submit an abstract to the American Academy of Optometry Residents Day Program.  
   2. Four case reports completed and submitted to TOA eNews.
Presentation:  
The Resident is required to deliver one presentation to fourth year optometry externs.  
Seminars:  
Specifics will be provided during residency orientation at Cedar Springs. The requirements described in the manual do not apply.
SUPERVISION POLICY

Supervision refers to the dual responsibility that the Program Coordinator and/or faculty attending have to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by a resident. Supervision is provided by observation, consultation and direction, and includes the imparting of knowledge, skills and attitudes by the practitioner to the resident.

Progressive responsibility for the care of the patient is a part of the resident's training program. The level of responsibility is commensurate with their acquisition of knowledge and development of judgement and skill. The resident’s knowledge and skills are assessed through the quality assurance process and formal evaluations of patient care.

Initially the resident is required to consult with their Program Coordinator or assigned attending faculty for all patients. In addition, all patient records must be co-signed by the Program Coordinator or supervising faculty member.

Consultation
When the Program Coordinator determines that the resident's knowledge, skills, and judgement are appropriate, the resident will no longer be required to consult with the Program Coordinator or assigned attending faculty for all cases. The Program Coordinator will define the types of cases, which require consultation and will notify the resident of the change in their supervision status. The resident will be encouraged to continually increase their independence in patient care throughout the residency. However, the opportunity for face-to-face consultation with the Program Coordinator or an attending faculty member is always available to the resident. For On-Call Service emergency/urgent patients, the initial consultation is by phone but the faculty assigned to On-Call will evaluate the patient if the resident requests a consultation.

Co-signing Charts
A requirement for continued co-signing of charts by the Program Coordinator or attending faculty is a decision made by individual Program Coordinators. Co-signing of charts may be discontinued when the Program Coordinator determines that the resident's knowledge, skills, and judgement are appropriate. A Coordinator may continue to co-sign all patient charts for the duration of the residency. However, all Program Coordinators will ensure quality of care provided by the resident by reviewing a selection of the resident's charts at least once a month throughout the residency. The Program Coordinator will notify the resident of any changes in co-signing requirements.

Clinical Attending
Residents will have an opportunity to serve as a clinical attending when the Program Coordinator has determined that the resident's knowledge, skills, and judgment are appropriate.
RESIDENT ON-CALL POLICY/REQUIREMENTS

- All residents will take on-call duties upon beginning their residency year.

- Residents on-call schedule
  - Residents will be responsible for developing their own on-call schedule utilizing the shared “On Call” calendar sent to them by the Associate Dean of the Professional Studies, Dr. Lambreghts.
  - Any changes made to the on-call schedule MUST be added to the shared “On Call” schedule.

- Faculty back-up on-call
  - Will be determined by the Associate Dean of Professional Studies and will be documented on the shared “On Call” calendar.
  - Residents need to check the On Call calendar a minimum of one week prior to their assignments. If the faculty phone # is not listed on the calendar, the resident needs to email the faculty to request their phone #.

- On-Call duties begin on Tuesday at 5:00pm and will end on Tuesday at 8:00am.

- Emergency calls that come into the UEI prior to 5:00pm will be triaged by the OD/Medical Service and either handled by clinic personnel or will be turned over to the resident on-call if the patient will arrive at the clinic after 5pm.

- On-call phone
  - Will be supplied to the Residents for on-call activities ONLY.
  - Will be serviced and tracked by the Associate Dean of Professional Studies.
  - It is the resident’s responsibility to alert Carl Branch of any issues regarding the on-call phone.
  - All phone calls must be answered by the resident on-call; calls must not be left to go to voice mail.
  - The on-call phone will be passed to the next resident scheduled to be on-call at Tuesday evening Grand Rounds.

- Triage
  - Residents are required to triage all calls that come into the on-call phone. However, after hours care is expressly for current (*seen within the last 3 years) UEI patients only.
  - Patient’s previous exam records may be accessed on the resident’s EMR laptop.
  - If a UEI patient or non-UEI patient has a non-emergent condition, the resident may tell the patient to present to the OD/Medical Service the next morning (provided the UEI is operating) at 8am. An email MUST also be sent to “OD_Med” in outlook to alert the staff that a patient might be on their way in the morning. Please provide the patients name, date of birth, and telephone number in that email.
  - If a non-UEI patient (including patients not seen in the last three years) has a true emergency, the resident MUST tell the patient to present to the emergency room.

- Faculty back-up on-call
  - Residents will be scheduled a faculty member available for consultation, as needed.
  - The resident will know in advance who this doctor is and how to reach them.
- Resident’s may call their back-up faculty at any time for consultation or help providing after-hours care.

  - **Providing after-hours care**
    - Any patient seen after hours needs to have an electronic medical record created for the visit.
    - The EMR template for these visits is titled “After Hours”.
    - This template should be opened in the OD/Med Service location.
    - Residents may see the patient in their designated examination lanes or in the OD/Med/medical Service. The exam template however, **MUST** be opened in the OD/ Med location.

  - **On-call “box”**
    - Is located in the OD/Med Service laboratory room (1371) and has all the necessary eye drops and antibiotics for in-house use **ONLY**, blank prescriptions, and other essentials.
    - The on-call resident **MUST** check the box for missing or expired drops sometime before they are to be on-call (the Friday or Monday before call begins). The residents have the responsibility to alert the OD/Med Coordinator or other staff member if there are any missing items or expired drops/contact lenses so these items may be replaced. Use OD_Med email to alert staff to expired or missing contents.
    - The residents **MUST** date and initial the **Residency Inventory Log** that is located inside the box each time they check the contents; which will be each time they are scheduled to be on-call.

  - **Coding and Billing for after hours patient care**
    - Both a paper fee bill and an electronic medical record **MUST** be generated for each after-hour’s patient that is seen.
    - The CPT (office visit) will be billed as either an Established Comprehensive (92014) or Established Intermediate ophthalmological (92012) **AND** a 99050 (services after posted office hours). Note the 99050 charge will not be covered by the patient’s insurance.
    - All ICD-9 (diagnosis) codes that apply **MUST** be documented in the EMR **AND** on the paper fee bill.
    - There are copies of a paper fee bill in the on-call box. These need to be filled out with the patients name, contact phone number and Patient ID number; found in ExamWriter under the demographics tab. The CPT codes are to be circled and the ICD-9 codes marked.
    - This fee bill **MUST** be filled out and signed by both the resident and the on-call faculty (if the resident is not a credentialed provider for the patient’s insurance).
    - The resident **MUST** get a contact phone number from the patient.
    - The fee bill is to be left on the OD/Med Coordinators desk for review.
    - Residents will **NOT** take any payment from the patient on the day of the after-hours visit.
    - The residents should inform the patient they will be billed for any co-pay, after hour’s charges ($65), or deductibles.
    - The patient can expect the OD/Med staff to call and confirm insurance information after the visit which will be billed if applicable.

  - **Security**
    - If the resident wishes to contact campus security for an escort into and out of the building after hours, the number is 713-743-3333.
Clinical Care Publications
Optometric Clinical Practice Guidelines and Quick Reference Guides

The following OCPGs are currently available:

Evidence-based Clinical Practice Guideline Comprehensive Adult Eye and Vision Examination (CPG1)
Now Available for Peer/Public Review until March 10, 2015.

Pediatric Eye and Vision Examination (CPG2)

Evidence-based Clinical Practice Guideline Eye Care of the Patient with Diabetes Mellitus (CPG3)
2014

Care of Patient with Amblyopia (CPG4)
1994 | Revised 1998 | Reviewed 2004

Care of the Patient with Primary Angle Closure Glaucoma (CPG5)

Care of the Patient with Age-Related Macular Degeneration (CPG6)
1994 | Revised 1999 | Reviewed 2004

Care of the Patient with Anterior Uveitis (CPG7)
1994 | Revised 1999 | Reviewed 2004

Care of the Adult Patient with Cataract (CPG8)
1995 | Revised 1999 | Reviewed 2004

Care of the Patient with Open Angle Glaucoma (CPG9)

Care of the Patient with Ocular Surface Disorders (CPG10)

Care of the Patient with Conjunctivitis (CPG11)

Care of the Patient with Strabismus: Esotropia and Exotropia (CPG12)
1995 | Revised 1999 | Revised 2010

Care of the Patient with Retinal Detachment and Peripheral Vitreoretinal Disease (CPG13)
1995 | Revised 1999 | Reviewed 2004

Care of the Patient with Visual Impairment (Low Vision Rehabilitation) (CPG14)

Care of the Patient with Myopia (CPG15)
1997 | Reviewed 2006

Care of the Patient with Hyperopia (CPG16)
1997 | Revised 2008

Care of the Patient with Presbyopia (CPG17)
1998 | Revised 2010

Care of the Patient with Accommodative and Vergence Dysfunction (CPG18)
1998 | Revised 2010

Care of the Contact Lens Patient (CPG19)

Care of the Patient with Learning Related Vision Problems (CPG20)
2000 | Revised 2008
PATIENT LOG

As noted in the program completion requirements, the resident is required to log each patient encounter throughout their residency program. This includes patient experience from direct patient care, by observation, and as a clinical attending. The exact format varies between programs, however most residents maintain an excel file. At minimum, the following information must be entered into the log:

1. Patient identifier
2. Date of visit
3. Diagnoses
4. Procedural codes
5. Level of involvement (direct, precepting, observational)

Additional information may be required. The log for each residency will be discussed during program specific orientation and the log template will be provided by your Program Coordinator.

The log should be updated frequently, weekly or more often. The log will be reviewed by the Program Coordinator on a regular basis.

The log has several purposes. It serves as an educational tool and resource for the resident. The Program Coordinator uses the log to monitor the resident’s patient care experiences to ensure the resident sees both an adequate number and variety of patients and uses the log to select cases for case discussion. The log is also used for by the Program Coordinator and Director of Residency Programs for program improvement purposes.
DEADLINES FOR RESEARCH PROJECT / PAPER

The following are the latest dates for submission. Failure to meet these deadlines may impact the resident’s ability to successfully complete the residency program.

October 5, 2015  Topic for review paper or original research project must be selected, approved by their Program Coordinator, and submitted to Director of Residency Programs. The topic with a 1 paragraph description must be turned in at Resident Journal Club.

December 7, 2015  Submission deadline for human subjects application to the College of Optometry Human Subjects Committee. This should allow submission to UHCPHS by the 1/5/15 deadline for the January meeting. Note with this submission deadline the earliest you will be able to commence data collection is February 1, 2015.

January 4, 2016  Literature search completed and submitted to their Program Coordinator

Original research has additional requirements –
  a) complete meeting with biostatistician (Program Coordinator must arrange), if needed,
  b) REQUIRED - human subjects application submitted to College Human Subjects Committee. Your application MUST be reviewed with your program coordinator prior to submission to the College Human Subjects Committee

Original research-submit human subjects application to UHCPHS for review at January meeting. This requires submission to the College Human Subjects Committee by mid November. HIPAA authorization must be submitted with the human subjects application and also provided to Dr. Pass.

May 9, 2016  Submit initial draft of paper to their Program Coordinator for review.

June 30, 2016  Final version of paper due to their Program Coordinator and Director of Residency Programs
DIDACTIC ACTIVITIES

Journal Club
First Friday of each month at Noon in room 2198. Some months a second journal club will be held, either as a third meeting or in place of the case discussions on the third Friday.

Case Discussions
Third Friday of each month at Noon in room 2198

Journal Club and/or Case Discussions may be rescheduled to other Fridays due to holidays or other residency events.

Seminars and Clinical Rounds
1. Residents are required to attend and complete **16 hours of continuing education** during their residency. The timing and specific requirements for topics and/or meeting are residency specific and will be covered during the orientation conducted by your Residency Program Coordinator. The details are also outlined on the following pages. Numerous local CE options are available with more than 70 hours of UHCO or HCOS CE in Houston yearly, both available at no-cost to residents (note: Clinical Rounds and required journal clubs may NOT be used toward the CE requirements).
   a. Harris County Optometric Society (HCOS) Meeting is held the last Tuesday of the month at 7PM. The schedule is typically available several months in advance and can be obtained by emailing Elizabeth Mauzy. Residents MUST RSVP as directed in the HCOS meeting email to take advantage of the meal provided at the College’s expense.
   b. Clinical Periopsias - if not assigned outside the building, held evenings or Noon, day and time varies. Announcements will be emailed to faculty and residents.
   c. UHCO continuing education programs
2. Residents are required to attend **Clinical Rounds** – held weekly during the academic semesters Tuesday evening from 5:30 to 7pm
3. Attendance is required at Resident Journal Clubs and Case Discussions.
4. Other meetings on Fridays at Noon as scheduled. These include programs with drug company representatives and other educational programs.
5. Other meetings or seminars as specified by individual program.

Additional seminars may be required. Meetings may be rescheduled to another day or time. All seminars that are required attendance for all residents will be posted on the Resident Calendar in Microsoft Outlook. The calendar is located in the Public Folders. It is the resident’s responsibility to review the calendar and track meeting dates.

**Attendance at these meetings should be documented in your patient/activity log.**

All residents are required to attend each meeting. Absences must be approved in advance by your Program Coordinator and Director of Residency Programs. See “Attendance” regarding unexcused absences.

If a resident is arriving late to meetings it is the responsibility of the resident and their program coordinator to modify the resident’s clinic schedule to ensure on-time arrival for meetings.
CE Requirements for Residents

Brain Injury Vision Rehabilitation Residency CE Requirements
A total of 16 hours of continuing education lectures obtained from Harris County Optometric Society, UHCO CE meetings, Periopsias, other journal clubs not required of the resident, other local CE lectures, and/or up to 6/16 hours of CE from AAO, AOA, or other national meetings. A minimum of 4/16 hours should be in the topic areas of: Neuro-optometry, Brain Injury, Low Vision, Pediatrics, and/or Binocular Vision. A minimum of 8/16 hours should be completed by the end of December.

Cornea & Contact Lens Resident CE Requirements
A minimum of 16 hours of continuing education is required. The hours cannot all be from one meeting and should be split between at least the Fall and Spring semesters. Acceptable sources of CE for the Cornea & Contact Lens Resident include:

- University of Houston College of Optometry CE Programs (but activities you are already required to attend such as Clinical Rounds, Resident Journal Club may not be used to fulfill the requirements). There is no cost for UHCO sponsored programs, but if the resident chooses to attend programs outside Houston, the resident will be responsible for travel costs.

- University of Houston College of Optometry Annual Cornea, Contact Lens, & Contemporary Vision Care Symposium (strongly recommended)

Global Specialty Lens Symposium (GSLS)  Highly recommended. Funding for registration may be available from B & L. Partial funding for travel, lodging may be available from the College if the resident is presenting a paper or poster.

- American Academy of Optometry (AAO)  Highly recommended (partial funding is available)

- Vision By Design (VBD)  Orthokeratology Meeting (registration may be paid by the organizers)

- American Optometric Association (AOA)  (partial funding may be available if the resident is also presenting a poster)

- Association for Research in Vision in Ophthalmology (ARVO)

- Texas Optometric Association (TOA)

- Harris County Optometric Association (HCOS)  (attendance funded by College)

- Clinical Periopsias

- Faculty Development Programs with CE credit

- Dry Eye, Anterior Segment journal clubs

- Other meetings may be approved if the request is submitted to the residency director for review and approval in advance.

- Funding is available as noted above. A minimum of 70 hours of CE is available at no cost in Houston (UHCO sponsored, HCOS, periopsias and faculty development programs).

- The resident must log the CE. In addition, proof of attendance must be supplied for all non-UHCO programs (including HCOS).

Family Practice Residency Continuing Education Requirements
The resident is required to complete 16 hours of continuing education during the residency year. Eight hours must be completed within the first 6 months of the residency program and the remaining 8 hours by May 31st prior to completion of the residency program. Two hours may be obtained from on-line continuing education. Grand Rounds and Resident Journal Club may not be used to fulfill the continuing education requirement as attendance at these is already required. The remaining hours must be obtained from the following sources:

- UHCO sponsored CE (no charge to resident – resident responsible for travel costs if chose to attend CE outside Houston)

- UHCO Periopsia or other faculty development offering CE credit

- HCOS (College will cover cost- resident must RSVP as directed in email)

- AAO (partial funding provided)

- SECO (no funding or partial funding if presenting a poster also)
Other sources of CE by approval of Residency Program Coordinator
The resident must log the CE hours and provide documentation of courses attended (with exception of UHCO sponsored CE and Periopsias – attendance is tracked by UHCO CE office).
The resident must complete the listed number of hours in the following areas. The exact courses are not designated. The resident may select the specific course(s) for each area.
1 hour Practice management
2 hours Lectures related to advanced technology
3 hours Medical Management – Therapeutic advances
2 hours Posterior Segment
2 hours Anterior Segment
2 hours Contact Lens
4 hours – Resident Selection on area of interest

**Residency in Low Vision Rehabilitation Didactic Curriculum**

Attendance is required at regularly scheduled resident journal club, resident case discussions, and Clinical Rounds. Residents may also be required to attend additional resident seminars or programs, as scheduled.
In addition to this formal didactic education provided by the College, 16 hours of continuing education is required. The resident is encouraged to attend continuing education that incorporates one or more of the following:
- Low vision rehabilitation diagnosis and management
- Diagnosis and management of ocular pathology resulting in vision loss (i.e. macular degeneration, glaucoma, diabetic retinopathy, etc.)
- Practice management solutions and techniques including coding and billing for primary care and low vision rehabilitation (CE hours from this objective are limited to 4 hours)

The residency program coordinator will review CE offered by HCOS, UHCO, as well as other meetings the resident may be attending, and may identify and require the resident attend specific programs.

The resident must log the CE hours and provide proof of CE attendance to the residency program coordinator, except for UHCO sponsored meetings as the records can be obtained from the UHCO CE department. Eight hours of CE is required between June and December and the remaining 8 hours is required between January and May.

**Options for local CE:**
Harris County Optometric Society (cost funded by UHCO) (10 hours offered) – residents must RSVP via email announcement to attend
UHCO sponsored CE (more than 50 hours offered yearly in Houston)
UHCO Clinical Periopsias
Faculty development programs with CE credit
UHCO journal clubs- dry eye, anterior segment

**CE may also be obtained at the following meetings:**
Note: Partial funding is provided to attend the AAO. Partial funding may be available, but is not guaranteed to attend other meetings, if the resident is presenting a poster.
AAO
AOA
Envision (yearly multidisciplinary conference, specific to low vision rehabilitation, Sept)
Ocular Disease Continuing Education Requirements
The resident is required to complete 16 hours of continuing education during the residency program year. The hours must be split with 8 hours obtained in both the 1st and 2nd 6 months of the program. Resident required activities such as journal club, case discussion, and Clinical Rounds may not be used to fulfill the continuing education requirements.
A minimum of 8 hours must be obtained from HCOS (typically 4 meetings). The College will cover the cost for the resident to attend HCOS meetings; if attending, please RSVP for planning purposes.
The remaining 8 hours may be obtained from any of the following:
AAO (partial funding provided)
AOA (partial funding may be provided if the resident is also presenting a poster at the meeting)
UHCO sponsored (no registration cost; the resident is responsible for their travel costs if they attend programs outside of Houston)
UHCO Periopsias
SECO (partial funding may be provided if the resident is also presenting a poster at the meeting)
Other programs by approval of Residency Program Coordinator
The resident must log the hours and provide evidence of attendance. It is not necessary to provide evidence of UHCO sponsored CE or periopsia as this is tracked by the College.

Breakdown of topics:
At least 12 of the required 16 hours must be ocular disease diagnosis and management topics, and/or pre- and post-surgical care topics:
- At least 4 hours of glaucoma diagnosis and/or management
- At least 2 hours of cataract and/or refractive surgery management
- At least 2 hours of anterior segment (ex: cornea, dry eye, uveitis)
- At least 4 hours of posterior segment (retina, optic nerve other than glaucoma)

PEDIATRIC OPTOMETRY RESIDENCY Continuing Education Requirements
A total of 16 hours of continuing education lectures obtained from Harris County Optometric Society, UHCO CE meetings, Periopsias, other journal clubs not required of the resident, other local CE lectures, and/or up to 6/16 hours of CE from AAO, AOA, or other national meetings. A minimum of 4/16 hours should be in the topic areas of: Pediatrics, Binocular Vision, Neuro-optometry, Brain Injury, and/or Low Vision. A minimum of 8/16 hours should be completed by the end of December.
ATTENDANCE

Attendance is **mandatory** for all lectures and other scheduled meetings. If an absence is planned, the resident needs to inform and receive approval for the absence from their Program Coordinator and the Director of Residency Programs, Dr. Fern, in advance of the absence. An unauthorized absence of one required meeting will result in a verbal reprimand and a letter of admonition in the resident's file. A second unauthorized absence will result in disciplinary action up to and including dismissal from the program.

Chronic tardiness at required meetings and Grand Rounds is not acceptable. If a resident is chronically tardy he or she will be given a verbal reprimand. If the tardiness continues, the resident will receive a letter of reprimand in his or her file. Further chronic tardiness can lead to disciplinary action up to and including dismissal from the program.

A typical clinic day is 8:00 A.M. to 5:00 P.M., Monday - Friday, unless additional time is required to prepare for or complete patient care. Tuesdays are 8:00 to 7:00 during the academic semesters which includes Clinical Rounds. Residents are assigned to On Call during evenings and weekends. When On Call the resident is also responsible for any post-operative visits scheduled on Saturdays.

An unauthorized absence from clinic will result in a letter of admonition in the resident's file. A second unauthorized absence will result in disciplinary action up to and including dismissal from the program. If a resident is chronically tardy he or she will be given a written reprimand. If the tardiness continues, it can lead to disciplinary action up to and including dismissal from the program.
RESIDENT CALENDAR

The 'Resident Calendar' is maintained in Microsoft Outlook. It is located within the 'Public Folder' section. You may access the calendar outside of the UHCO Network (e.g., from home) through your office computer. The calendar is not available via the web-based log-in.
LICENSING

Residents are required to obtain a Texas Optometry License including the Optometric Glaucoma Specialist certification. As of May 2008 the Texas Optometry Board has ruled that applicants graduated in 2008 or later from currently accredited US Colleges of Optometry and from the University of Waterloo are not be required to take the post-graduate glaucoma education previously required for this certification.

Residents must submit their application to the Texas Optometry Board within 30 days of notification of optometric licensure. Your Residency Program Coordinator will sign your application to attest to the clinical skills component.
The good judgment of the resident is relied upon regarding clothing and personal appearance, as there is no clinic dress code for residents or faculty. Resident dress and appearance should be professional during regular clinic hours and when providing emergency care after hours. Individual Program Coordinators will address any concerns regarding a resident's appearance directly with the resident. The Student Dress Code is attached for reference, however this code has only been adopted for students.
UEI STUDENT DRESS CODE

General Concepts

A. Clinic Jackets
1. Clinic jackets will be of an approved style for men and women
2. Clinic jackets will be cleaned and pressed
3. The UEI emblem should be securely sewn over the left breast pocket
4. Each student should have their name monogrammed in consistent red block font (as selected by administration), just above the left breast pocket
5. Only UEI, UH, BSK, or state or national optometric logos (TOA, AOA) should be attached to the jacket, not to exceed 3 pins total
6. Clinic jackets will be worn at all times unless faculty direct otherwise

B. Hygiene
1. All standard hygiene rules apply
   a. No offensive breath or body odors
   b. Minimal use of cologne or perfumes
2. Nails should be clean, short, and well kept (this includes feet for women wearing peep-toe shoes)
3. Hair should be clean and neatly styled
4. Facial hair should be well kept or if no facial hair, should be clean shaven

C. Piercing
1. Only ear piercing is allowed for women
2. Ear pierces should not be above the ear lobe
3. Men are NOT to wear earrings in clinic

D. Tattoos
   1. Tattoos MUST be covered at all times

WOMEN

When in clinic, but not seeing patients; women should wear either clinic attire or:
- Khaki or dress slacks
- Button down shirt, polo-like shirt, or sweater
- Casual or dress shoes
- No shorts, jeans, sweatshirts, caps, athletic shoes, or open-toe sandals allowed

When in clinic seeing patients:
Shoes:
- Must be in good repair
- Shoes may be close-toed dress shoes, peep-toe dress shoes, or closed-toe sandals (as long as they have a strap around the ankle)
- NO open-toe sandals, NO flip-flops, NO shoes with all toes exposed, NO athletic style shoes

Skirts or dresses:
- Skirts or dresses should be no more than an inch above the knee
- Skirts or dresses that are above the knee should not be slit on the side
- Skirts or dresses that are below the knee should not have slits that go above the knee

Shirts:
- Can be long or short sleeved
- Halter-tops, or shirts with spaghetti straps ARE NOT TO BE WORN
- Women must wear a bra
- Shirts must have a modest neckline (i.e., a patient should not be able to see down the front of the top)
- Sleeveless shirts are acceptable, as long as they are non-revealing
- Exposed midriffs are NOT allowed

Pants:
- Pants can be dress slacks or khakis
- Capri pants must be at least MID-Calf in length and NO SHORTER
- NO shorts allowed

Hose:
- Legs must be covered if your skirt is above the knee (i.e., hose are required)
- Leggings and tight pants are NOT allowed
- Hose are not required for pants or for skirts or dresses that are closer to the ankles than to the knees

MEN
When in clinic but not seeing patients; men should wear either clinic attire or:
- Khaki or dress slacks
- Button down shirt, polo-like shirt, or sweater
- Casual or dress shoes
- No shorts, jeans, sweatshirts, caps, athletic shoes, or sandals allowed

When in clinic seeing patients:
- Dress shirt (with long or short sleeves) and a tie
- Dressy sweater may be worn over shirt and tie
- Dress khaki or dress slacks
- Shoes must be dress shoes, in good repair, and polished if applicable

SEXUAL AND OTHER HARASSMENT AND DISCRIMINATION POLICIES

University of Houston System Administrative Policies (SAM) related harassment and discrimination are available online for residents to review as needed.

01.D.04 Affirmative Action Policy
http://www.uh.edu/af/universityservices/policies/sam/1GenAdmin/1D4.pdf

01.D.07 Discrimination and Harassment Policy
http://www.uh.edu/af/universityservices/policies/sam/1GenAdmin/1D7.pdf

01.D.08 Sexual Misconduct Policy
http://www.uh.edu/af/universityservices/policies/sam/1GenAdmin/1D8.pdf
PROCEDURES FOR DISMISSAL AND GRIEVANCE

A resident may be terminated for academic deficiency:
1) insufficient fund of optometric and/or medical knowledge
2) inability to use optometric or medical knowledge effectively in patient care or lack of appropriate technical skills;
3) other deficiency which bears on the resident's academic performance.

Non-academic deficiencies may also result in termination:
1) violation of professional responsibility
2) violation of UEI policies and procedures
3) any unprofessional act, such as absence without a valid excuse, chronic tardiness, violation of outside employment rule, conviction of a crime (felony or drug offense), unprofessional conduct, unprofessional care of patients, any action which jeopardizes the safety of patients, personnel, or physical facilities, and lying, cheating, or stealing.

Minor infractions of professional behavior will result in a letter of reprimand from the Director of Residency Programs.

The procedure for dismissal for academic or non-academic deficiency follows:
If a resident's performance is determined to be below acceptable standard, he/she will be informed in writing by the Director of Residency Programs that the resident is on probation to begin on the date of notification. This written notification will include a description of the below standard performance, the remedial action expected, and the result of failure to remediate the problem. The resident will receive two (2) copies of the notification. The resident retains one copy. The second copy is signed by the resident as acknowledgement of receipt and returned to the Director of Residency Programs. During the probationary period, the resident may seek advice, tutorial assistance, or other aid to correct deficiencies in an effort to remain in the Residency Program. The length of the probationary period will be determined based on the type and severity of deficiency, but typically will not exceed six weeks. The length of probation will be indicated in the notification.

At the end of probation, the Director of Residency Programs will elect one of the following:
1) Remove resident from probation
2) Extend probation
3) Recommend dismissal of resident

Probation may be extended for a period to be determined and the resident will be provided additional suggestions for improving performance. At the end of the probationary period, if the resident performance is satisfactory, probation will end.

If dismissal is recommended, a meeting between the Director of Residency Programs, Program Coordinator, and the resident will be held to allow the resident an opportunity to respond and identify facts that may alter the decision. If the outcome of this meeting is a recommendation of termination the Dean will be notified. The resident may submit their resignation or has five days to implement grievance procedures, if desired. In cases of unprofessional conduct or academic deficiencies that compromise patient care, the resident will be terminated immediately, but the appeal process is still available.

The grievance process, informal or formal, may be implemented by the resident at any point in the above disciplinary process or as a result of a performance evaluation. The University of Houston employee grievance process is outlined in MAPP 2.04.01, Employee Grievances (http://www.uh.edu/af/universityservices/policies/mapp/02/020401.pdf) and 2.04.03, Discipline and Dismissal of Staff Employees (http://www.uh.edu/af/universityservices/policies/mapp/02/020403.pdf).
LENGTH OF RESIDENCY, SALARY, AND BENEFITS

Each clinical residency will be a minimum of one calendar year in length, commencing no later than June 22 and ending on June 30. Benefits include all staff privileges including:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
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<tbody>
<tr>
<td>Salary</td>
<td>$38,000 per year</td>
</tr>
<tr>
<td>Vacation/Development</td>
<td>8 hours per month</td>
</tr>
<tr>
<td>Sick Leave</td>
<td>8 hours per month</td>
</tr>
<tr>
<td>Travel Stipend</td>
<td>$700 to one approved meeting – additional funds may be available for the meeting if the resident presents a poster or paper. Funds may also be available for additional meetings if the resident has a poster or presentation accepted.</td>
</tr>
<tr>
<td>Health Benefits</td>
<td>Medical insurance as outlined at UH orientation</td>
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<tr>
<td>Retirement Program</td>
<td>As outlined at UH orientation</td>
</tr>
<tr>
<td>Professional Liability Insurance</td>
<td>Provided by the College for all patient care activities associated with the residency program</td>
</tr>
<tr>
<td>Other insurance</td>
<td>Dental, short and long term disability, and life available at resident’s expense</td>
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<tr>
<td>1 clinic coat</td>
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<tr>
<td>Use of College, University and Texas Medical Center Library including inter-library loan and available electronic journals</td>
<td></td>
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<tr>
<td>Continuing education conducted by UHCO and HCOS at no cost to resident.</td>
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LEAVE
Vacation
The university provides paid vacation for benefits-eligible employees. Eight hours of vacation is earned per month. Residents should submit their leave request for approval via PASS and are encouraged to select the dates they wish to take vacation as far in advance as possible. The process is described below. Vacation will be granted as requested, provided the work schedule permits. Weekends are not counted as vacation time.

The resident is responsible for notifying attendings and service coordinators of any absence to allow adjustment of patient scheduling. If the resident wants to take a vacation day when they are on-call, it is the resident's responsibility to arrange On-call Service coverage by trading with another resident. The resident initiating the trade must also modify the On Call Calendar.

Unless special exception is made, no more than two residents may be on vacation at any given time.

The month of July and June: Vacation is discouraged during this time and only allowed under special circumstances with approval from the Director of Residency Programs.

Days when students are not in clinic (e.g., holidays, final exams) - There are some provisions for additional time off at Christmas or other student holidays, however the number of days and residents who may be absent is limited. The Director of Residency Programs will coordinate leave during student holidays. No guarantee will be made for the amount of vacation to be allowed during the Christmas holidays. One or more resident will be on-call over this time period.

The dates when vacation is restricted include:
July 2015
August 17-21, 2015
October 6-10, 2015 (if not attending AAO meeting)
November 23 and 25, 2015
December 4, 2015-January 5, 2016
February 19, 2016
March 7-11, 2016
April 19-May 9, 2016
June 2016

Exams - Time away to take Boards or any other licensing exam will be charged as annual leave.

Development Leave: Limited Development Time (vacation will not be charged) will be provided to attend one major meeting including the annual Academy meeting, AOA Congress, ARVO, SECO or SWCO. Vacation time must be used to attend additional days/meetings.

Official University Holidays
Independence Day Friday, July 3, 2015
Labor Day Monday, September 7, 2015
Thanksgiving Thursday and Friday, November 26-27, 2015 (Wednesday Nov. 25 is a student holiday. It is NOT a staff holiday – residents will see patients.)
Winter Holiday official dates not yet available – at minimum, December 24, 2015-January 1, 2016 – These dates will be provided to residents as soon as the Board of Regents approves the staff holiday schedule.
Martin Luther King  Monday, January 18, 2016
Memorial Day  Monday, May 30, 2016

The clinics will be closed on these holidays. However, residents will still be responsible for On-Call Service assignment during University Holidays. The residents will coordinate the On-Call schedule for holidays occurring after Labor Day.

Student holidays and other dates clinics are closed for students but are NOT staff holidays listed above

These include but may not be limited week of spring break, break after fall, spring and summers semesters, Wednesday before Thanksgiving and College clinic closures (e.g., Friday of the TOA annual meeting, AAO Annual meeting, and clinical competency examination).

These are not holidays for residents. Residents are expected to provide patient care during these times. The only exception is during the AAO annual meeting. Residents are excused from clinic to attend the AAO meeting. However, if a resident chooses to not attend the AAO meeting they will be assigned to provide urgent-emergency care during business hours (resident must be in building 8 to 5 Tuesday through Friday) and will also be responsible for On-Call Service outside of regular business hours.

Sick Leave

The university handbook describes the use of sick leave and personal time off and may only be used for these described purposes. Unused sick leave CANNOT be used as vacation time. All full-time regular employees earn sick leave beginning on the first day of employment. Sick leave is earned at the rate of eight hours for each month or a fraction of a month of employment. Unused sick leave is carried forward each month and may be accumulated throughout the residency program. For additional information pertaining to sick leave, please refer to the University of Houston’s Staff Handbook.

Procedures for Requesting Leave

Sick Leave
1. Submit via PASS system – log into Access UH. Instructions will be provided at University orientation. Enter dates in advance for appointments (planned sick leave) and on the first day back at work when ill.

For planned sick leave submit at least 1 month in advance, if possible, and complete these steps also
2. Request approval of Program Coordinator for specific date(s) of absence via email.
3. Notify rotation(s) of absence. This includes Service Coordinator and faculty supervising you in rotation.
4. Forward this email of approval to Dr. Fern, Director of Residency Programs. Leave will not be approved until the approval email is received.

Vacation
1. The Resident must check the On-call schedule. The resident is responsible for arranging a trade with another resident if scheduled for On-call during the planned vacation. Vacation will not be approved until this trade is documented on the On-Call calendar.
2. Check if the leave is during restricted vacation times. If it is, the Resident is responsible for stating this in their vacation request.
3. Obtain email approval from program coordinator. This should be completed at least one month in advance. The approval by your program coordinator must be forwarded to Dr. Fern.
4. Notify rotation(s) of absence. This includes Service Coordinator and faculty supervising you in rotation.

5. PASS system submission

- **Leave taken prior to January 1.** Do NOT submit to PASS until after January 1. Prior to January 1 the system will not authorize vacation requests as your employment is less than 6 months. During January, the Resident must submit all hours of leave taken June through December (or up to the maximum hours the Resident has accrued to date) to the PASS system. Additional hours taken prior to January 1 must be submitted as the vacation hours are accrued.

- **Leave taken after January 1.** Submit at least one month in advance of date through the PASS system (can log in via Access UH using CougarNet).

The above noted restrictions apply. Requests for vacation leave are not automatically approved.

**Unapproved absence:** If a resident is not present at his/her assignment, the time of absence is counted either as annual vacation or sick leave.
TRAVEL
Up to a $700 stipend is available to residents attending one of the following meetings:
American Academy of Optometry (AAO)
AOA Congress (requires special vacation approval)
ARVO
SECO

Additional funds may be available if the resident presents a paper or poster at the meeting.
Also partial funding may be provided to an additional meeting if presenting paper or poster.
Funding may be available to attend meetings other than those listed above. Approval of the
meeting by the Director of Residency Programs is required.

The following procedures must be adhered to for you to be reimbursed for your travel expenses,
however, it is possible a new on-line procedure may be implemented by the University prior to the
Academy Meeting. Residents will be notified of any changed in the procedure.

1. A Travel Request (available in the Business Office) must be approved by the Director of
   Residency Programs and submitted in the Business Office at least 30 days PRIOR to taking the
   trip. Your travel expenses can NOT be reimbursed if you fail to submit the request prior to travel.
   This also includes local (in town) travel for reimbursement for parking expenses. Ask your
   Program Coordinator for assistance in completing the form. Note the University has recently placed
   additional restrictions regarding the inclusion of non-University travel dates with University travel.
   You are allowed travel days- the day immediately preceding the first day of the meeting and the
day immediately after the last day of the meeting. Combining non-business travel with business
tavel may prevent reimbursement of all or part of your airfare. In addition, no reimbursement is
allowed for meals or parking on non-business days. If you are considering the inclusion of a non-
business travel day(s) with business travel, contact Mary Guzman in the business office prior to
making any travel arrangement to understand the impact this may have on your reimbursement.

2. Airline tickets may be purchased with your personal funds. You will be reimbursed up to the
   approved amount for the meeting but will not be reimbursed until after travel is completed. Tickets
   may be purchased with University funds (you will not have to wait for reimbursement) from the
   University approved travel agency and are subject to a nominal service charge. See Mary Guzman
   for details.

3. The Travel request must be resubmitted to the Business Office within 30 days after the
   completion of travel, otherwise you will NOT be reimbursed. The following documentation must
   be included:
   a. Copy of airline ticket itinerary
   b. Original receipt for payment of hotel bill. It must include your name, the nights billed for, and
      indicate the amount paid.
   c. Receipts are required for reimbursement for transportation (taxi, bus, shuttle), airport parking,
      and registration.
   d. While receipts are not required for meals it is best to keep receipts as University policy limits
      your reimbursement to the amount spent, but not to exceed the per diem set for the city.

Residents may defray travel costs by applying for a travel fellowship from the American
Academy of Optometry and/or applying for a limited number of hotel rooms available for
students/residents at a reduced fee. The deadline for the travel fellowship application is
August 4, 2014. Information is available at http://www.aaopt.org/students/stf
COMPUTER ACCESS AND AUDIOVISUAL ASSISTANCE

Each resident will be provided with a computer with Internet access, needed software (Microsoft Office), and an email address provided at University orientation. For assistance with hardware or software issues contact OPT-IT-Support@uh.edu (in Outlook address book) or if email is not working you may call Darrin Nguyen (X31403).

Your CougarNet ID and password are required to log onto your computer, the network server for the EMR, and your web-based email access.

Username and password for EMR will be provided at the College orientation. This is NOT your CougarNet password.

For assistance with PowerPoint, audiovisual needs, or information on preparation of posters for optometric meetings - see Kimberley Thompson (X31744)
OUTSIDE OPTOMETRIC EMPLOYMENT

As an employee of the University of Houston you may work as an optometrist outside the College of Optometry affiliated clinics. If you choose to do so you must adhere to the following rules:

1) University system policy limits outside paid consultation or paid professional service to an average of 1 day in 7.
2) These activities must not interfere with patient care or program activities (i.e. seminars).
3) You may not work outside the College when you are “on-call”.
4) You must obtain your own malpractice insurance. Your professional liability insurance for your residency does not cover these patient care activities.
5) You may not use your DEA number obtained through the College unless the fees are paid to the Texas DPS and the DEA for your numbers. If the numbers are used only at the College the fees are waived by the respective agencies. If you want to use the number at an outside practice you will need to pay the fees for the DPS and DEA numbers.
MEDICAL RECORD REVIEW

The Program Coordinator will review a random selection of the resident's medical records. The number of records and frequency of review is program specific. Record review will entail an analysis of all aspects of the examination including the history, examination, assessment, management, and patient education. You should receive feedback from your Program Coordinator.
RESIDENT EVALUATION OF ROTATION, ATTENDINGS AND PROGRAM COORDINATORS

Each resident is requested to provide feedback on various Attendings, Program Coordinators, and clinical rotations. These evaluations will be completed on Meditrek. You will receive an email notification when the evaluation opens. You are required to complete the evaluations to provide feedback on rotation strengths and weaknesses and any suggestions for improving the rotation. Program Coordinators and Attendings are evaluated after the first summer semester (evaluation opens mid-Aug to mid-Sept) and fall semester (mid-Dec to mid-Jan). Near the end of the program year (mid-June) each resident will evaluate his or her entire training and experience, and a self-assessment (for comparison to assessment completed at the beginning of the program) in addition to Rotations, Attendings and Program Coordinator evaluations. Some programs also utilize an additional self-assessment completed in December-January.

Faculty do not have access to the individual evaluations until the resident has completed the program. The Director of Residency Programs and Program Coordinators will follow up on suggestions noted in the evaluations. Evaluations of a resident’s Program Coordinator will not be available to the Coordinator until after the completion of the residency experience, however, residents are encouraged to share comments and suggestions with their Coordinator that they feel will enhance their residency experience. The Director of Residency Programs reviews the Program Coordinator evaluations and addresses issues, as needed, during the residency year.
RESIDENT EVALUATION OF ROTATION AND TEACHING EFFECTIVENESS

RESIDENT _____________________ ROTATION _______________ DATES ______

List and describe any deficiencies or problems encountered while on service.

Adequacy of teaching material?________________________________________________________

________________________________________________________________________

Adequacy of supervision and teaching?_________________________________________

________________________________________________________________________

Was resident's role and responsibility well defined?______________________________

________________________________________________________________________

Received feedback on performance during rotation?_____________________________________

________________________________________________________________________

Assigned appropriate level of responsibility for patient care?________________________

________________________________________________________________________

Opportunity to discuss patients with faculty?_____________________________________

________________________________________________________________________

Effectiveness of patients for didactic purposes?___________________________________

________________________________________________________________________

Able to exercise clinical judgment?____________________________________________

________________________________________________________________________

Other problems___________________________________________________________

________________________________________________________________________
Overall rating of rotation: OUTSTANDING  GOOD  SATISFACTORY  INADEQUATE
(select one)

How beneficial was this rotation to your training?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List three (3) objectives you expected to achieve from rotation:
1. _______________________________________________________________________
2. _______________________________________________________________________
3. _______________________________________________________________________

Was there any subject(s) you expected to cover during rotation but did not?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Any suggestions for improving the rotation? ____________________________________
________________________________________________________________________
________________________________________________________________________

If you found the service less than adequate, do you think it should be eliminated from the
rotation schedule? YES  NO

If yes, what alternative would you suggest? ____________________________________
________________________________________________________________________
________________________________________________________________________

Any additional comments? __________________________________________________
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<td>1.</td>
<td>The Attending is available in the Service to provide supervision.</td>
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<td>2.</td>
<td>The Attending is skilled in clinical techniques</td>
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<td>3.</td>
<td>The Attending is knowledgeable about recent developments in the field.</td>
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<td>4.</td>
<td>The Attending is able to accurately assess the resident's strengths and weaknesses.</td>
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<td>5.</td>
<td>The Attending is willing to demonstrate techniques to the resident when appropriate.</td>
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<td>6.</td>
<td>The Attending discusses the interpretation of signs, symptoms, and data with the resident.</td>
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<td>7.</td>
<td>The Attending encourages the resident to learn new concepts and/or techniques.</td>
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<td>8.</td>
<td>The Attending provides adequate clinical experiences for the resident.</td>
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<td>9.</td>
<td>The Attending is approachable with suggestions, questions, and for assistance.</td>
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<td>10.</td>
<td>The Attending provides feedback to the resident in a timely manner.</td>
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<td>11.</td>
<td>The Attending provides criticism to the resident in a constructive manner away from the patient.</td>
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<td>12.</td>
<td>The Attending demonstrates sensitivity to the resident's needs.</td>
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13. The Attending is open to other points of view or alternative techniques.

14. The Attending has a genuine interest in helping residents become better doctors.

15. The Attending demonstrates sensitivity to the patients' needs and feelings.

16. The Attending guides the resident in making referrals and seeking consultation when appropriate.

17. The Attending has a good working relationship with other staff members.

18. The Attending conveys a sense of professionalism.

19. The Attending conducts effective seminars.

20. The Attending suggest specific ways for residents to improve.

Comments on any of the above items:

In reference to the working relationship with your Attending, please indicate what you liked best, what you liked least, and what recommendations you would offer to improve the working relationship. (Please use the back of the sheet if necessary.)
UNIVERSITY OF HOUSTON COLLEGE OF OPTOMETRY
EVALUATION OF RESIDENCY PROGRAM COORDINATOR
Resident's Name____________________________________Date___________________

Coordinator's Name__________________________________________________________

Instructions: Select one of the following responses for each statement listed below:
   SA = Strongly Agree
   A = Agree
   D = Disagree
   SD = Strongly Disagree
   NA = Not Applicable, Did Not Observe, or Don't Know

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14. The Coordinator encourages independent study.  

15. The Coordinator encourages the resident to gain experience in clinical and didactic teaching.  

16. The Coordinator provides opportunities for the resident to interact with other health professionals.  

17. The Coordinator conducts the residency in an organized manner.  

18. The Coordinator conveys a sense of professionalism.  

19. The Coordinator is knowledgeable on all aspects primary eye care.  

20. The Coordinator demonstrates and shares diagnostic skills, techniques, and strategies.  

21. The Coordinator allows the resident enough flexibility and independence to develop diagnostic and management skills.  

22. The Coordinator is readily available for second opinions and consultations.  

23. The Coordinator ensures that the Service is well maintained and equipped with state-of-the-art equipment.  

24. My objectives for the residency program are being met.  

Comments on any of the above items:

In reference to the working relationship with your Coordinator please indicate what you liked best, what you liked least, and what recommendations you would offer to improve the working relationship. (Please use the back of the sheet if necessary).
Please rate the following aspects of the Residency Program:

A  = Excellent  
B  = Good  
C  = Fair  
D  = Poor  
N/A = Does not apply

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<th>C</th>
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A. Clinical Education

1. Number of patient encounters
2. Quality of patient encounters
3. Quality of clinical supervision

B. Other Clinical Education

1. Vision Screenings
2. Other

C. Didactic Education

1. Literature review
2. Grand Rounds
3. Special lectures or CE courses attended

D. Teaching

1. Serving as an instructor to optometry students
2. Presenting lectures and labs to optometry students
3. Serving as a clinical Attending to optometry students
4. Presenting CE courses to optometrists

D. Research

1. Research opportunities
2. Research guidance and supervision
PLEASE COMMENT ON THE FOLLOWING:

1. How satisfied were you with the residency program?
   a) Very satisfied
   b) Fairly satisfied
   e) Somewhat dissatisfied
   f) Very dissatisfied

2. Strengths of the residency program

3. Weaknesses of the program

4. Suggestions for improvement

5. Additional comments (Use the back of this page if you require additional space)

Signature______________________________________________________

Date_______________________________
EVALUATION OF RESIDENT CLINICAL PERFORMANCE

Residents are evaluated by the Residency Program Coordinator and faculty a minimum of three times per year: August, January, and June. Performance evaluations may be completed in April if concern exists about the resident’s clinical knowledge and/or skills.

The Program Coordinator will review the evaluations with the resident to provide feedback to aid the resident in improving their clinical knowledge and skills.

In addition, the resident completes a self-assessment a minimum of two times during the program – at the beginning and end. The self-assessment provides a measure of the resident’s success to the resident and the program.

These evaluations will be available on-line; they are completed by faculty in Meditrek system.

The evaluations and self assessment for each program are located in the following pages.
In order to provide the resident with feedback on performance strengths and weaknesses, faculty evaluation of resident performance is scheduled periodically. Performance reviews will be conducted at the end of each semester and at the completion of the residency. The Residency Director will review and discuss these evaluations with the resident and the evaluations will remain in the resident’s permanent file.

The rating scale is as follows:

- **5** Significantly above entry level. Performance of superior, advanced quality. The resident knows what to do, when, and does it within a reasonable length of time in a thorough and consistent manner.
- **4** Above entry level. Performance of advanced quality, strong but not yet superior.
- **3** Entry level. Performance is average and meets that expected of an entry level optometrist. Performance meets our minimum standards.
- **2** Less than entry level. Performance falls below our minimum standards expected of an entry level optometrist.
- **1** Unsatisfactory. Performance is far below our minimum standards expected of an entry level optometrist.
- **0** Unable to evaluate at this time / Not applicable

**General Diagnostic Skill Sets:**

- Obtains thorough and accurate histories including CC & HPI
- Utilizes appropriate VA tests based on patient age, cognitive status, and/or verbal abilities
- Knowledge & implementation of binocular & accommodative tests
- Refractive error determination (retinoscopy & refraction)
- Knowledge & implementation of developmental tests (VPS, APS, etc)
- Utilizes appropriate visual field tests based on patient age, cognitive status, and/or verbal abilities
- Ocular health diagnostic skills
- Examinations are systematic and efficient
- Ability to modify standard techniques to work with various populations (pediatric, learning disorders, multiply impaired children, acquired brain injury, etc.)

**Comments:** (Please comment on any score of 1, 2, or 5 to help justify evaluation)

---

**General Knowledge, Integration, & Application to Clinical Care:**
- Traumatic brain injury 0 1 2 3 4 5
- Stroke 0 1 2 3 4 5
- Neurologic conditions 0 1 2 3 4 5
- Non-strabismic binocular vision & accommodation disorders 0 1 2 3 4 5
- Strabismus 0 1 2 3 4 5
- Children with special needs (syndromes, CP, autism, etc) 0 1 2 3 4 5
- Ocular urgencies & emergencies 0 1 2 3 4 5
- Application of literature to patient care 0 1 2 3 4 5

Comments: (Please comment on any score of 1, 2, or 5 to help justify evaluation)

---

**Verbal & Written Communication Abilities With:**

- Patients/Parents 0 1 2 3 4 5
- Optometrists/Ophthalmologists 0 1 2 3 4 5
- Non-healthcare professionals 0 1 2 3 4 5
- Other healthcare professionals 0 1 2 3 4 5

Comments: (Please comment on any score of 1, 2, or 5 to help justify evaluation)

---

**Responsibility:**

- Timely to clinic, meetings, answering pages, etc 0 1 2 3 4 5
- Completes records and reports in a timely fashion 0 1 2 3 4 5
- Recognizes limitations and seeks advice, consultation, or referral as needed 0 1 2 3 4 5
- Utilizes feedback to continually improve clinical care 0 1 2 3 4 5

Comments: (Please comment on any score of 1, 2, or 5 to help justify evaluation)

---

**Overall Competence:**

- Rate the resident's overall skill and knowledge as an optometrist 0 1 2 3 4 5

Comments: (Please comment on any score of 1, 2, or 5 to help justify evaluation)
Based on observations, indicate the resident’s overall strengths/deficiencies to qualify your overall evaluation:


Please report any problems involving moral character, integrity, motivation, and interpersonal relationships:


Please note any additional comments you may have:


Degree of contact with resident:
- Little or no contact
- Sporadic contact
- Frequent but superficial contact
- Close contact

Supervisor Signature: __________________________________________________________

Date: ___________________________
CEDAR SPRINGS
Evaluation of Ocular Disease Resident Clinical Performance/Competence

Resident: _____________________________  Semester: __________________

Attending: ____________________________  Rotation: ______________________

Level of contact with the resident (circle): Minimal / Sporadic / Frequent / Close

Grading Scale:

5 = **Significantly above entry level.** Performance of superior, advanced quality. The resident exhibits a superior knowledge base and application of that knowledge to provide superior patient care in a consistent manner.

4 = **Above entry level.** Performance of advanced quality, but not superior.

3 = **Entry level.** Performance is average and that expected of an entry level optometrist. Meets minimum standards.

2 = **Less than entry level.** Performance falls below minimum standards expected of an entry level optometrist.

1 = **Unsatisfactory.** Performance is far below our minimum standards expected of an entry level optometrist.

0 = **Unable to evaluate**

**General Skills**

1. Able to perform routine tests and procedures at expected level.  
2. Data is accurate and reliable.  
3. Recognizes need for ancillary tests and procedures  
4. Works to correct skill deficits/weaknesses  
5. Strives to improve patient care abilities

**Specific Skills**

1. Basic health assessment skills (SLE, +78D, BIO)  
2. Pachymetry  
3. Gonioscopy  
4. Automated visual fields – interpretation  
5. OCT – retina  
6. OCT – retinal nerve fiber layer  
7. GDx  
8. B-scan ultrasonography  
9. Fluorescein angiography  
10. Scleral depression  
11. Specular microscopy  
12. Foreign body removal (cornea/conjunctiva)  
13. Other skills specific to rotation:

   a. ____________________________ 0 1 2 3 4 5
   b. ____________________________ 0 1 2 3 4 5
   c. ____________________________ 0 1 2 3 4 5

**General knowledge, integration, and application to clinical care**
1. Dry eye 0 1 2 3 4 5
2. Blepharitis 0 1 2 3 4 5
3. Other eyelid disorders 0 1 2 3 4 5
4. Conjunctivitis 0 1 2 3 4 5
5. Corneal dystrophies, degenerations 0 1 2 3 4 5
6. Infectious keratitis 0 1 2 3 4 5
7. Uveitis 0 1 2 3 4 5
8. Lens disorders/cataracts 0 1 2 3 4 5
9. Glaucoma – chronic 0 1 2 3 4 5
10. Glaucoma – acute 0 1 2 3 4 5
11. Diabetic retinopathy 0 1 2 3 4 5
12. Retinal vascular occlusive disease 0 1 2 3 4 5
13. Hypertensive retinopathy 0 1 2 3 4 5
14. Age-related macular degeneration 0 1 2 3 4 5
15. Optic nerve anomalies other than glaucoma 0 1 2 3 4 5
16. Other knowledge specific to rotation:
   a. ___________________________________ 0 1 2 3 4 5
   b. ___________________________________ 0 1 2 3 4 5

**Diagnosis and management**

1. Diagnostic capabilities 0 1 2 3 4 5
2. Appropriate knowledge of differential diagnoses 0 1 2 3 4 5
3. Diagnosis approached in logical manner 0 1 2 3 4 5
4. Seeks appropriate consultation when needed 0 1 2 3 4 5
5. Uses appropriate references/resources 0 1 2 3 4 5
6. Integrates evidence-based medicine into diagnosis/management 0 1 2 3 4 5
7. Management plan is developed logically 0 1 2 3 4 5
8. Remains open to new management options/concepts 0 1 2 3 4 5
9. Follows through with patient management, including referral letters, follow-up appointments 0 1 2 3 4 5

**Communication**

1. Establishes comfortable and professional rapport with patients 0 1 2 3 4 5
2. Establishes comfortable and professional rapport with faculty 0 1 2 3 4 5
3. Establishes comfortable and professional rapport with staff 0 1 2 3 4 5
4. Effectively communicates patient case presentations to faculty 0 1 2 3 4 5
5. Effectively communicates condition/plan with patient 0 1 2 3 4 5
6. Displays empathy to patients facing serious conditions 0 1 2 3 4 5
7. Provides patients with appropriate instructions to enhance adherence to prescribed plan (written, verbal) 0 1 2 3 4 5
8. Effectively communicates with other optometrists and physicians 0 1 2 3 4 5
### Medical records
1. Completes all records and reports in a prompt manner 0 1 2 3 4 5
2. Patient records are neat and accurate 0 1 2 3 4 5
3. Appropriate coding and billing 0 1 2 3 4 5

### Clinical Conduct and responsibility
1. Is on time to all clinical assignments 0 1 2 3 4 5
2. Is dependable 0 1 2 3 4 5
3. Exercises initiative within the limits of knowledge and training 0 1 2 3 4 5
4. Recognizes limitations and seeks advice & consultation when needed 0 1 2 3 4 5
5. Accepts constructive criticism from faculty 0 1 2 3 4 5
6. Provides constructive feedback regarding faculty and rotations 0 1 2 3 4 5
7. Conveys a sense of professionalism 0 1 2 3 4 5
8. Treats staff with respect 0 1 2 3 4 5
9. Conveys empathy and respect to patients 0 1 2 3 4 5

Based on observations during this rotation, indicate resident’s strengths and weaknesses:

**Strengths:**
1. 
2. 
3. 

**Weaknesses:**
1. 
2. 
3. 

**Additional Comments:**

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Supervisor Signature: ___________________________ Date: __________________

Resident Signature: ___________________________ Date: __________________
EVALUATION OF CORNEA AND CONTACT LENS RESIDENT CLINICAL COMPETENCE

RESIDENT _____________________________ DATES ________________

ATTENDING ___________________________ ROTATION _______________________

I. EXAMINATION

5 4 3 2 1 0  (1) Obtains thorough and accurate histories. (vs. Incomplete or inaccurate)

5 4 3 2 1 0  (2) Examinations are performed systematically and efficiently. (vs. Disorganized or unduly slow)

5 4 3 2 1 0  (3) Data is accurate and reliable. (vs. Imprecise and unreliable)

5 4 3 2 1 0  (4) Rechecks doubtful results when appropriate. (vs. Fails to recheck doubtful findings)

II. RELATIONSHIP WITH PATIENT

5 4 3 2 1 0  (1) Establishes comfortable and professional rapport with patients. (vs. Gruff or cold)

5 4 3 2 1 0  (2) Conveys empathy and respect to patients. (vs. Aloof or disrespectful)

5 4 3 2 1 0  (3) Calm when dealing with hostile patients or emotional displays. (vs. Visibly agitated)

III. PROBLEM SOLVING AND CLINICAL JUDGMENT

5 4 3 2 1 0  (1) Accurately identifies presenting problem consistent with clinical data. (vs. Has difficulty identifying presenting problems)

5 4 3 2 1 0  (2) Demonstrates knowledge of differential diagnosis. (vs. limited potential etiologies)

5 4 3 2 1 0  (3) Has a good store of pertinent factual information. (vs. Has basic deficiencies in factual medical information)

5 4 3 2 1 0  (4) Shows sound judgment on problem priorities. (vs. Has poor idea of problem priorities)

5 4 3 2 1 0  (5) Demonstrates knowledge of different specialty lens designs and the conditions for which they are used. (vs. Haphazard trial and error fitting)

5 4 3 2 1 0  (5) Takes all data into account and regularly tests alternative hypotheses. (vs. Leaves loose ends in problem formulation)
IV. IMPLEMENTING PATIENT MANAGEMENT PLAN

5 4 3 2 1 0 (1) Formulates treatment plans which are comprehensive, correct and in logical order. (vs. incomplete, inaccurate, or disorganized)

5 4 3 2 1 0 (2) Is fully aware of side effects of drugs. (vs. Has little understanding of side effects)

5 4 3 2 1 0 (3) Provides clear instructions to patients and checks whether patient understands. Provides written instructions when needed. (vs. Is confusing in instructions and fails to determine comprehension)

5 4 3 2 1 0 (4) Reassesses problems and modifies therapy as needed. (vs. Switches therapy often, ignoring basic therapeutics or protocols)

5 4 3 2 1 0 (5) Management plans include the appropriate use of references and/or resources. (vs. Does not appropriately use resources)

V. USE OF LAB OR OTHER INVESTIGATIONS

5 4 3 2 1 0 (1) Is discriminating in use of laboratory or other investigative procedures and provides clear rationale for tests ordered. (vs. Frequently orders inappropriate tests or does not have clear rationale)

5 4 3 2 1 0 (2) Interprets lab results or ancillary testing intelligently, integrating and evaluating them with other patient data.-vs. Unduly influenced by abnormal results and fails to integrate results with other findings)

5 4 3 2 1 0 (3) Is aware of the normal ranges of tests ordered. (vs. Unaware of normal ranges)

5 4 3 2 1 0 (4) Considers costs when ordering ancillary tests. (vs. Unaware of costs)

VI. MEDICAL RECORDS

5 4 3 2 1 0 (1) Completes all records and reports promptly (vs. Postpones completion of records and reports)

5 4 3 2 1 0 (2) Patient charts are neat and understandable. (vs. Unintelligible to others)

5 4 3 2 1 0 (3) Documents information in an organized and systematic manner. (vs. Medical notes are disorganized or inadequate)

Yes___ No___ (4) Medical records are adequate so that others can easily treat patients.

VII. RESPONSIBILITY

5 4 3 2 1 0 (1) Recognizes limitations and seeks advice, consultation, or referral when
needed. (vs. Accepts too much responsibility relative to capability)

5 4 3 2 1 0  (2)  Exercises initiative within the limits of knowledge and training. (vs. Requests guidance in making decisions that resident should be able to make)

5 4 3 2 1 0  (3)  Can be depended upon to perform duties. (vs. Cannot be depended upon)

5 4 3 2 1 0  (4)  Reports facts accurately, including own errors. (vs. Attempts to cover up errors)

5 4 3 2 1 0  (5)  Works diligently to correct skill deficits which become apparent. (vs. Shows no initiative to improve performance)

5 4 3 2 1 0  (6)  Is available to assist others as required. (vs. Reluctant to assist others)

5 4 3 2 1 0  (7)  Provides evaluations and positive criticism regarding supervisory faculty and clinical programs. (vs. Submits cursory evaluations void of comments or suggestions)

IX. ORAL PRESENTATIONS

5 4 3 2 1 0  (1)  Clinical case presentations are well organized and thorough. (vs. Unorganized and incomplete)

5 4 3 2 1 0  (2)  Rounds, Journal Club, and Case Discussion presentations are well researched, organized and thorough. (vs. Unprepared and disorganized)

5 4 3 2 1 0  (3)  Provides appropriate, knowledgeable answers to questions. (vs. Unable to answer questions)

X. MISCELLANEOUS

5 4 3 2 1 0  (1)  Adheres to schedule; arrives promptly to clinic, conferences, or Rounds. (vs. Tardy or absent)

5 4 3 2 1 0  (3)  Responds to pages quickly. (vs. Ignores page requests)

5 4 3 2 1 0  (4)  Offers and receives advice in a tactful and discreet manner. (vs. Has difficulty giving or taking advice)

5 4 3 2 1 0  (5)  Establishes and maintains positive rapport with faculty and colleagues. (vs. Negative attitude or poor interpersonal skills)

XI. OVERALL EDUCATIONAL PROGRESS

5 4 3 2 1 0  (1)  Acquired appropriate level of optometric and medical knowledge while on rotation. (vs. Made minimal increases)

5 4 3 2 1 0  (2)  Overall competence as an optometrist.
Based on observations, indicate resident's overall strengths/deficiencies to qualify your overall evaluation


Problems involving moral character, integrity, motivation, interpersonal relationships should be documented


Any additional comments?


Degree of contact with resident:

Little or no contact _____  Sporadic contact _____  Frequent but superficial contact _____

Close contact _____

Supervisor ___________________________  Date ________________

(Signature)

Resident ___________________________  Date ________________

(Signature)
Family Practice Evaluation of Resident Clinical Competence

Resident: __________________________           Semester: _______________________

Attending: __________________________   Rotation: __________________________

Level of Contact with the resident: Minimal / Sporadic / Frequent / Close

Grading Scale: 1-5
1: Far below expectation
2: Below Expected
3: Expected
4. Exceeds expectations
5. Excellent

Technical Skills
1. Is able to perform tests and procedures expected for current level in program. 1 2 3 4 5
2. Data is accurate and reliable. 1 2 3 4 5
3. Understands purpose/value of tests being utilized. 1 2 3 4 5
4. Recognizes need for specialized ancillary tests and procedures. 1 2 3 4 5
5. Works aggressively to correct skill deficits which become apparent. 1 2 3 4 5
6. Resident strives to improve patient care ability. 1 2 3 4 5

Organizational Skills
1. Examination sequence development is appropriate for current level in program. 1 2 3 4 5
2. Gathers an orderly problem-oriented case history and clearly defines the reason-for-visit/chief complaint. 1 2 3 4 5
3. Analyzes clinical data in a logical sequential manner. 1 2 3 4 5
4. Develops orderly sequential, legible clinical records and documents. 1 2 3 4 5
5. Completes examinations and procedures within an appropriate amount of time for current level in program. 1 2 3 4 5

Diagnosis and Assessment
1. Diagnostic capabilities are appropriate for current level in program. 1 2 3 4 5
2. Demonstrates appropriate knowledge of differential diagnoses. 1 2 3 4 5
3. Diagnosis is approached in a logical manner, with appropriate consultation with resident supervisor. 1 2 3 4 5
4. Diagnosis is appropriately consistent with clinical data. 1 2 3 4 5
5. Diagnosis involves appropriate use of references/resources. 1 2 3 4 5
6. Integrating evidence based medicine into patient management. 1 2 3 4 5

Management and Treatment
1. Management and treatment development is appropriate for current level in program. 1 2 3 4 5
2. Plan is developed logically and with appropriate faculty consultation. 1 2 3 4 5
3. Plan developed is appropriate for assessment/diagnosis reached. 1 2 3 4 5
4. Management plans, treatments, therapies, prescriptions, etc. are formulated through the use of appropriate references/resources. 1 2 3 4 5
5. Remains open to new management options and concepts. 1 2 3 4 5
6. Follows through with patient management, appropriate RTC date, and
referral letters and appointments.

Communication
1. Establishes comfortable and professional rapport with patients.  
2. Establishes comfortable and professional rapport with faculty.  
3. Effectively presents significant aspects of chief complaint, patient history, clinical findings, assessment and management plans (as appropriate for current level in program); makes an appropriate case presentation.  
4. Effectively communicates findings/plan to patient following all appropriate discussions with supervisory faculty.  
5. resident involves the patients in the decision making process relative to their treatment plan.  
6. Professionally controls patient encounters.  
7. Provides patients with instructions likely to result in compliance with treatment and therapy plans.

Medical Records
1. Completes all records and reports promptly.  
2. Patient charts are neat and legible.  
3. Records information in an organized and systematic manner  
4. Appropriate coding and billing

Clinical Conduct
1. Accepts positive criticism regarding clinical performance  
2. Provides positive criticism regarding supervisory faculty  
3. Conveys a sense of professionalism  
4. Conveys empathy and respect to patients.

Responsibility
1. Recognizes limitations and seeks advice, consultation, or referral when needed.  
2. Exercises initiative within the limits of knowledge and training.  
3. Dependable.  
4. Works diligently to correct skill deficits.  
5. Is on time to all clinical assignments.

Based on observations, indicate resident’s overall strengths/deficiencies to qualify your overall evaluation:________________________________________________________________________
__________________________________________________________________________________

Additional Comments:__________________________________________________________________________________
__________________________________________________________________________________

Supervisor Signature:________________________  Date:_________________

Resident Signature:__________________________  Date:________________
In order to provide residents with feedback on performance strength and weaknesses, faculty evaluation of resident performance is scheduled periodically. Performance reviews will be conducted at the end of each semester and at the completion of the residency.

Individual evaluations are numerically averaged to provide each resident a summary evaluation which includes a paragraph to qualify performance.

Twice a year, in November and June, residents will meet with faculty to review the summary evaluation and discuss comments. Faculty-Resident conferences will be scheduled for each resident, to meet with two faculties. The summary evaluations are included in the resident’s permanent file. The rating scale is as follows:

5 Outstanding. Performance is of superior quality. Knows what to do, when, and does it within a reasonable length of time in a thorough and consistent manner.

4 Very Good. Performance is of very good quality – strong, but not yet superior.

3 Average. Performance meets OUR minimum standards.

2 Needs improvement. Performance falls below OUR minimum standards.

1 Unsatisfactory. Performance is far below OUR minimum standards.

N/A No able to assess
Resident’s Evaluation of Knowledge & Skills  
Low Vision Rehabilitation

Resident’s Name: ___________________________  Date: __________
Attending: ________________________________

Summer/Spring/Fall (circle one)  Year: __________
LVR Rotation: CSE/Baylor/TiRR/other: ___________ (circle location which applies)

History

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1. Determine ocular condition and history (including stability and continued care with referring physician)

2. Determine and document a case history as it relates to visual function (e.g., including present and prior use of optical aids, co-morbidities)

3. Determine specific visual goals (if more than one, prioritize)

Examination

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4. Assessment and documentation of visual acuity, eccentric viewing and functional performance

5. Assessment and documentation of additional testing when needed

6. Problem oriented approach (vs. non-systematic or “cookbook” approach

Management

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7. Allow patient to participate in decision-making regarding clinical management

8. Patient/caregiver counseling and education is complete and compassionate including delivering “bad news” (e.g. cessation of driving

9. Near optical options: Calculates and applies the different concepts for magnification

10. Eccentric viewing plan: designing an appropriate training plan, modify as needed and/or cease training to look at other options

11. Intermediate options: Understands and is able to calculate the magnification and construct the appropriate optical system

12. Distance options: Understands and is able to calculate the magnification, choose appropriate training device and construct the final appropriate optical system

13. Electronic/computer needs: recognize advantages/disadvantages for each system to provide most appropriate technology for the patient’s goals

14. Field enhancement for hemianopic field losses: design device and training plan

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15. Field enhancement for peripheral constriction: design device and training plan including co-manage with allied rehab professionals regarding orientation & mobility.

16. Filters/tints: prescribed appropriately to enhance comfort and visual function.

17. Appropriate management patients with brain injury (e.g., traumatic, stroke and visual neglect including training

18. Appropriate referrals to allied professionals including orders of training and services.

19. Clearly communicate with referring professionals to ensure their understanding of the plan of action including cessation of LVR care (oral or in writing)

20. Demonstrates knowledge of state, regional and national law/regulations pertaining to individuals with, or at risk for visual impairment and is able to communicate this information to the patient

21. Driving: fitting bioptic when necessary and training including co-management with other professional

22. Demonstrates broad understanding and familiarity with a range of low vision devices and respective vendors

23. Follows clinical protocols for loaning devices.

24. Applies current information from the literature/evidence based medicine to patient’s management

**Records/Coding/Billing**

25. Current understanding of appropriate coding and billing related to low vision rehabilitation services necessary for successful reimbursement

26. Follows appropriate procedures and documentation for billing through contract, state agencies, third party etc.

27. Records are legible and organized

28. Records and letters are completed in a timely manner

**Responsibility**

29. Adheres to clinic schedule, arrives on time, dependable

30. Recognizes limitations and seeks consultation when appropriate

31. Diligently works to improve knowledge and skills

32. Accepts advice in a constructive manner

33. Positive attitude and rapport with faculty and other residents
Resident’s Evaluation of Knowledge & Skills

Summer/Spring/Fall  (circle one)  Year: ____________
LVR Rotation: CSE/Baylor/TiRR/other: ____________ (circle at the apply)
Degree of contact:

Overall this resident _________________ is:
(Print resident’s name)

☐ Improving and increasing their knowledge as expected
☐ Not shown adequate increase in knowledge

Overall this resident is ready for independent low vision patient care at which level?  (Circle one)

Introductory LV
- No worse than 20/40
- No visual field loss

Advanced LV
- VA’s 20/70-20/100
- Minimal field loss
- Rx stock items

Highly Advanced LV
- Custom fit distance and near devices
- Rx field enhancing devices

Comments on strengths/deficiencies:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Problems involving moral character, integrity, motivation, interpersonal relationships:
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Supervising Attending Signature: ________________________  Date: __________________

This evaluation has been discussed /reviewed by the resident and the Coordinator.

Resident’s Signature: _________________________________  Date: __________________

Program Coordinator Signature: __________________________
Evaluation of Ocular Disease Resident Clinical Performance/Competence

Resident: ___________________________  Semester: __________________

Attending: __________________________  Rotation: __________________

Level of contact with the resident (circle): Minimal / Sporadic / Frequent / Close

Grading Scale:

5 = **Significantly above entry level.** Performance of superior, advanced quality. The resident exhibits a superior knowledge base and application of that knowledge to provide superior patient care in a consistent manner.

4 = **Above entry level.** Performance of advanced quality, but not superior.

3 = **Entry level.** Performance is average and that expected of an entry level optometrist. Meets minimum standards.

2 = **Less than entry level.** Performance falls below minimum standards expected of an entry level optometrist.

1 = **Unsatisfactory.** Performance is far below our minimum standards expected of an entry level optometrist.

0 = **Unable to evaluate**

**General Skills**

1. Able to perform routine tests and procedures at expected level. 0 1 2 3 4 5
2. Data is accurate and reliable. 0 1 2 3 4 5
3. Recognizes need for ancillary tests and procedures 0 1 2 3 4 5
4. Works to correct skill deficits/weaknesses 0 1 2 3 4 5
5. Strives to improve patient care abilities 0 1 2 3 4 5

**Specific Skills**

1. Basic health assessment skills (SLE, +78D, BIO) 0 1 2 3 4 5
2. Pachymetry 0 1 2 3 4 5
3. Gonioscopy 0 1 2 3 4 5
4. Automated visual fields – interpretation 0 1 2 3 4 5
5. OCT – retina 0 1 2 3 4 5
6. OCT – retinal nerve fiber layer 0 1 2 3 4 5
7. GDx 0 1 2 3 4 5
8. B-scan ultrasonography 0 1 2 3 4 5
9. Fluorescein angiography 0 1 2 3 4 5
10. Scleral depression 0 1 2 3 4 5
11. Specular microscopy 0 1 2 3 4 5
12. Foreign body removal (cornea/conjunctiva) 0 1 2 3 4 5
13. Other skills specific to rotation:

   a. __________________________________________ 0 1 2 3 4 5

   b. __________________________________________ 0 1 2 3 4 5

   c. __________________________________________ 0 1 2 3 4 5
General knowledge, integration, and application to clinical care

1. Dry eye
2. Blepharitis
3. Other eyelid disorders
4. Conjunctivitis
5. Corneal dystrophies, degenerations
6. Infectious keratitis
7. Uveitis
8. Lens disorders/cataracts
9. Glaucoma – chronic
10. Glaucoma – acute
11. Diabetic retinopathy
12. Retinal vascular occlusive disease
13. Hypertensive retinopathy
14. Age-related macular degeneration
15. Optic nerve anomalies other than glaucoma
16. Other knowledge specific to rotation:
   a. __________________________________________
   b. __________________________________________

Diagnosis and management

1. Diagnostic capabilities
2. Appropriate knowledge of differential diagnoses
3. Diagnosis approached in logical manner
4. Seeks appropriate consultation when needed
5. Uses appropriate references/resources
6. Integrates evidence-based medicine into diagnosis/management
7. Management plan is developed logically
8. Remains open to new management options/concepts
9. Follows through with patient management, including referral letters, follow-up appointments

Communication

1. Establishes comfortable and professional rapport with patients
2. Establishes comfortable and professional rapport with faculty
3. Establishes comfortable and professional rapport with staff
4. Effectively communicates patient case presentations to faculty
5. Effectively communicates condition/plan with patient
6. Displays empathy to patients facing serious conditions
7. Provides patients with appropriate instructions to enhance adherence to prescribed plan (written, verbal)
8. Effectively communicates with other optometrists and physicians
Medical records
1. Completes all records and reports in a prompt manner 0 1 2 3 4 5
2. Patient records are neat and accurate 0 1 2 3 4 5
3. Appropriate coding and billing 0 1 2 3 4 5

Clinical Conduct and responsibility
1. Is on time to all clinical assignments 0 1 2 3 4 5
2. Is dependable 0 1 2 3 4 5
3. Exercises initiative within the limits of knowledge and training 0 1 2 3 4 5
4. Recognizes limitations and seeks advice & consultation when needed 0 1 2 3 4 5
5. Accepts constructive criticism from faculty 0 1 2 3 4 5
6. Provides constructive feedback regarding faculty and rotations 0 1 2 3 4 5
7. Conveys a sense of professionalism 0 1 2 3 4 5
8. Treats staff with respect 0 1 2 3 4 5
9. Conveys empathy and respect to patients 0 1 2 3 4 5

Based on observations during this rotation, indicate resident’s strengths and weaknesses:

Strengths: 1.

2.

3.

Weaknesses: 1.

2.

3.

Additional Comments:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Supervisor Signature: ___________________________ Date: ___________________________  
Resident Signature: ___________________________ Date: ___________________________
In order to provide the resident with feedback on performance strengths and weaknesses, faculty evaluation of resident performance is scheduled periodically. Performance reviews will be conducted at the end of each semester and at the completion of the residency. The Residency director will review and discuss these evaluations with the resident and the evaluations will remain in the resident’s permanent file.

The rating scale is as follows:

5  **Significantly above entry level.** Performance of superior, advanced quality. The resident knows what to do, when, and does it within a reasonable length of time in a thorough and consistent manner.

4  **Above entry level.** Performance of advanced quality, strong but not yet superior.

3  **Entry level.** Performance is average and meets that expected of an entry level optometrist. Performance meets our minimum standards.

2  **Less than entry level.** Performance falls below our minimum standards expected of an entry level optometrist.

1  **Unsatisfactory.** Performance is far below our minimum standards expected of an entry level optometrist.

0  **Unable to evaluate at this time.**

### General Diagnostic Skill Sets:

- Obtains thorough and accurate histories including CC & HPI
- 0 1 2 3 4 5
- Utilizes appropriate VA tests based on patient age & cognitive status
- 0 1 2 3 4 5
- Knowledge & implementation of binocular & accommodative tests
- 0 1 2 3 4 5
- Refractive error determination (retinoscopy & refraction)
- 0 1 2 3 4 5
- Knowledge & implementation of developmental tests (VPS, APS, etc)
- 0 1 2 3 4 5
- Ocular health diagnostic skills
- 0 1 2 3 4 5
- Examinations are systematic and efficient
- 0 1 2 3 4 5
- Ability to modify standard techniques to work with various populations
- (pediatric, learning disorders, multiply impaired children, acquired brain injury, etc.)
- 0 1 2 3 4 5

**Comments:** (Please comment on any score of 1, 2, or 5 to help justify evaluation)

---

**General Knowledge, Integration, & Application to Clinical Care:**

- Development of visual function
- 0 1 2 3 4 5
- Non-strabismic binocular vision & accommodation disorders
- 0 1 2 3 4 5
- Strabismus & amblyopia
- 0 1 2 3 4 5
- Developmental, perceptual, & learning based disorders
- 0 1 2 3 4 5
Children with special needs (syndromes, CP, autism, etc) 0 1 2 3 4 5
Acquired brain injury & neurologic conditions 0 1 2 3 4 5
Ocular urgencies & emergencies 0 1 2 3 4 5
Application of literature to patient care 0 1 2 3 4 5

Comments: (Please comment on any score of 1, 2, or 5 to help justify evaluation)

Verbal & Written Communication Abilities With:

- Patients/Parents 0 1 2 3 4 5
- Optometrists/Ophthalmologists 0 1 2 3 4 5
- Non-healthcare professionals 0 1 2 3 4 5
- Other healthcare professionals 0 1 2 3 4 5

Comments: (Please comment on any score of 1, 2, or 5 to help justify evaluation)

Responsibility:

- Timely to clinic, meetings, answering pages, etc 0 1 2 3 4 5
- Completes records and reports in a timely fashion 0 1 2 3 4 5
- Recognizes limitations and seeks advice, consultation, or referral as needed 0 1 2 3 4 5
- Utilizes feedback to continually improve clinical care 0 1 2 3 4 5

Comments: (Please comment on any score of 1, 2, or 5 to help justify evaluation)

Overall Competence:

- Rate the resident’s overall skill and knowledge as an optometrist 0 1 2 3 4 5

Comments: (Please comment on any score of 1, 2, or 5 to help justify evaluation)
Based on observations, indicate the resident’s overall strengths/deficiencies to qualify your overall evaluation:


Please report any problems involving moral character, integrity, motivation, and interpersonal relationships:


Please note any additional comments you may have:


Degree of contact with resident:

- Little or no contact
- Sporadic contact
- Frequent but superficial contact
- Close contact

Supervisor Signature: __________________________________________________________

Date: __________________________
UHCO Brain Injury Vision Rehabilitation Resident
Initial Self Evaluation

Name of Resident:_________________________
Date of Evaluation:________________________

Approximately how many patients in each category below did you see as an optometry student:
- Traumatic Brain Injury: ____________
- Stroke: ____________
- Neurologic Disease: ____________
- Nonstrabismic BV/Accom disorders: ____________
- Strabismic disorders: ____________
- Special needs/multiply impaired: ____________
- Infants (0-18 mos): ____________
- Toddlers (19-36 mos): ____________
- Preschoolers (3-5 yrs): ____________
- School age kids (6-17yrs): ____________

How confident are you with your knowledge in the following areas?

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<th>Not at all Confident</th>
<th>Moderately Confident</th>
<th>Very confident</th>
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- Functional brain anatomy
- Visual pathway from eye through brain
- Cranial nerve pathways
- Cranial nerve assessment
- Refractive error development and norms
- Binocular vision (motor & sensory) development & norms
- Visual acuity development and norms
- Color vision development
- General developmental milestones for infants, toddlers, preschoolers
- Current clinically relevant literature (evidence based medicine):
  - Amblyopia Treatment Study (ATS) results
  - Convergence Insufficiency Treatment Trial (CITT) results
- Nonstrabismic BV and accommodative disorders
- Perceptual and learning related disorders
- Strabismic disorders
  - Comitant
  - Non-comitant (cranial nerve palsies)
- Neuro-ophthalmic disorders
- Common ocular/visual sequelae found in special needs populations
- Common ocular pathology found in the pediatric population
- Common ocular pathology as related to emergency on-call
- Ancillary diagnostic tests (i.e. GDX, OCT, HRT, automated VF)
- Prescribing ocular and systemic medications for ocular problems
- How pediatric tests are applied to brain injury population
How confident are you with the following **diagnostic skills**?

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- Unique history questions related to acquired brain injury (i.e. Glasgow Coma Scale (GCS), loss of consciousness) 0 1 2 3 4 5
- Unique history questions related to infants, toddlers, preschoolers 0 1 2 3 4 5
- Full HPI related to strabismus 0 1 2 3 4 5
- Full HPI related to diplopia 0 1 2 3 4 5
- Informal assessment of VA and how to document (RTO, F&F) 0 1 2 3 4 5
- Object acuity calculations (determining VA based on object size and test distance viewed) 0 1 2 3 4 5
- 2 alternative forced choice acuity testing (i.e. TAC, Cardiff) 0 1 2 3 4 5
- Nonverbal / Preschool VA testing with matching paradigm (i.e. Lea, HOTV) 0 1 2 3 4 5
- Bailey-Lovie VA testing & logMar calculations 0 1 2 3 4 5
- Nonverbal / Preschool Contrast Sensitivity testing (i.e. Hiding Heidi) 0 1 2 3 4 5
- Low vision magnification assessment 0 1 2 3 4 5
- Retinoscopy (especially loose lens) & prescribing directly from results 0 1 2 3 4 5
- MEM retinoscopy 0 1 2 3 4 5
- Cover test, Hirshberg, Krimsky 0 1 2 3 4 5
- Comitancy testing (including Park’s 3 step) 0 1 2 3 4 5
- Double Maddox rod evaluation of torsion 0 1 2 3 4 5
- Visuoscopy evaluation of eccentric fixation 0 1 2 3 4 5
- Retinal correspondence assessment 0 1 2 3 4 5
- Preschool stereo tests (Lang, Preschool Randot, Frisby) 0 1 2 3 4 5
- Objective vergence assessment (prism bars, etc) 0 1 2 3 4 5
- Associated phoria testing (Wesson, vectographic slide) 0 1 2 3 4 5
- Developmental Testing (Denver, SASP, PASP, Rutgers) 0 1 2 3 4 5
- Tonopen IOP measurements 0 1 2 3 4 5
- Hand held slit lamp 0 1 2 3 4 5
- Visual field testing (i.e. 30-2 SITA fast HVF, Estermann, confrontation) 0 1 2 3 4 5
- Ocular health eval of special populations 0 1 2 3 4 5
- Anterior segment evaluation as it relates to emergency red eyes 0 1 2 3 4 5
- Foreign body removal of the anterior segment 0 1 2 3 4 5
- Gonioscopy evaluation of the anterior chamber angle 0 1 2 3 4 5
- Scleral depression for suspected retinal holes, tears, detachments 0 1 2 3 4 5

How confident are you with **diagnosing** the following conditions?

<table>
<thead>
<tr>
<th>Never Performed</th>
<th>Not at all Confident</th>
<th>Moderately Confident</th>
<th>Very confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

- Nonstrabismic BV/Accom disorders 0 1 2 3 4 5
- Strabismus 0 1 2 3 4 5
- Amblyopia 0 1 2 3 4 5
- Cranial nerve palsies 0 1 2 3 4 5
- Developmental/perceptual delays 0 1 2 3 4 5
- Nystagmus 0 1 2 3 4 5
- Visual impairment: cortical & other congenital/early onset disorders (i.e. Optic nerve hypoplasia, Leber’s) 0 1 2 3 4 5
- Visual/ocular disorders of preterm infants 0 1 2 3 4 5
  - List the disorders you are aware of:
- Visual/ocular disorders of special needs patients
  - List the disorders you are aware of:

- Visual/ocular disorders of brain injury/stroke patients
  - List the disorders you are aware of:

- Pediatric ocular pathology
- Ocular urgencies/emergencies

How confident are you with the following management options?

<table>
<thead>
<tr>
<th></th>
<th>Never Performed</th>
<th>Not at all Confident</th>
<th>Moderately Confident</th>
<th>Very confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing glasses for infants, toddlers, preschoolers considering normal development of RE, VA, and BV anomalies?</td>
<td>0 1 2 3 4 5</td>
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<tr>
<td>Prescribing best sensory Rx for BV/Accom disorders including adds</td>
<td>0 1 2 3 4 5</td>
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<tr>
<td>Prescribing prism for BV disorders</td>
<td>0 1 2 3 4 5</td>
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<tr>
<td>Designing and implementing vision therapy plans for nonstrabismic BV/Accom disorders</td>
<td>0 1 2 3 4 5</td>
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<tr>
<td>Using computer orthoptic programs for VT:</td>
<td>0 1 2 3 4 5</td>
<td></td>
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<tr>
<td>- HTS vergence therapy program</td>
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<tr>
<td>- HTS amblyopia therapy program</td>
<td>0 1 2 3 4 5</td>
<td></td>
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<tr>
<td>Determining whether strabismus would be best managed by observation, glasses (RE, add, prism), VT, and/or surgery</td>
<td>0 1 2 3 4 5</td>
<td></td>
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<tr>
<td>Designing and implementing VT plans for strabismic disorders</td>
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<tr>
<td>Prescribing amblyopia therapy</td>
<td>0 1 2 3 4 5</td>
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<tr>
<td>- Patching</td>
<td>0 1 2 3 4 5</td>
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<td>- Atropine</td>
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<tr>
<td>- Active VT (monoc and binoc)</td>
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<tr>
<td>Making functional recommendations to parents &amp; teachers for special needs patients</td>
<td>0 1 2 3 4 5</td>
<td></td>
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</tr>
<tr>
<td>Making functional recommendations to teachers for the visually impaired &amp; special ed teachers for visually impaired patients</td>
<td>0 1 2 3 4 5</td>
<td></td>
<td></td>
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<tr>
<td>Managing visual disorders of brain injury/stroke patients</td>
<td>0 1 2 3 4 5</td>
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<td></td>
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</tr>
<tr>
<td>Making functional recommendations to therapists (occupational, physical and speech) and rehabilitation physicians (physiatrist) regarding functional vision and visual limitations</td>
<td>0 1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your ability to understand and apply current scientific literature into patient care through evidence based clinical decision making?</td>
<td>0 1 2 3 4 5</td>
<td></td>
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Other:

<table>
<thead>
<tr>
<th></th>
<th>Never Performed</th>
<th>Not at all Confident</th>
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<th>Very confident</th>
</tr>
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<tbody>
<tr>
<td>How confident are you with your oral and written communication abilities with:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patients/parents</td>
<td>0 1 2 3 4 5</td>
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<td></td>
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<tr>
<td>- Teachers</td>
<td>0 1 2 3 4 5</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Optometrists</td>
<td>0 1 2 3 4 5</td>
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<tr>
<td>- Ophthalmologists</td>
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</tr>
<tr>
<td>- Therapists (occupational, physical, speech)</td>
<td>0 1 2 3 4 5</td>
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<td></td>
<td></td>
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<tr>
<td>- Physicians (physiatrists, pediatricians)</td>
<td>0 1 2 3 4 5</td>
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</tr>
</tbody>
</table>
- How do you rank your formal presentation skills (e.g. lectures, presentations) to:
  - Optometry students: 0 1 2 3 4 5
  - Optometrists: 0 1 2 3 4 5
  - Other professionals: 0 1 2 3 4 5

- How confident are you in your ability to continually improve your patient care through self-assessment and quality assurance evaluations: 0 1 2 3 4 5

Please list any goals for your residency, as well as any areas in which you want to improve over the course of your residency.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
CEDAR SPRINGS RESIDENT SELF-ASSESSMENT

RESIDENT_________________________ DATE____________________

The purpose of this form is to allow you to rate your skills, knowledge and experience in areas related to the diagnosis and management of ocular disease and ocular manifestations of systemic disease. You will complete this assessment at the beginning and end of the program. The purpose of the self-assessment is to 1) aid your residency program coordinator in creating an optimal residency program for you and 2) allow you and your program coordinator to track your development throughout your residency.

Rate your confidence using the scale below for the following test, conditions:
0=No experience with a patient
1= not confident/ limited experience
2
3= moderately confident /moderate experience
4
5= very confident / extensive experience

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<tr>
<th>Diagnostic Tests</th>
<th>Perform</th>
<th>&amp;</th>
<th>Interpret</th>
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<tr>
<td>1. Gonioscopy</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Automated visual fields</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
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<tr>
<td>3. OCT - Cirrus</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. OCT - OptoVue</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
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<tr>
<td>5. Digital Acutome B-Scan</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>6. A-Scan</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
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<tr>
<td>7. Visucam Fundus Camera</td>
<td>1 2 3 4 5</td>
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<td>8. Paschial Tonometry</td>
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<td>9. OPTOS retinal imaging</td>
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<td>10. OPD Wavefront Analysis</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
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<td>11. Flourescein angiography</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
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<tr>
<td>12. Laboratory tests</td>
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<tr>
<td>Selecting needed tests</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Interpreting tests</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Management of...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Dry eyes</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>14. Uveitis</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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<tr>
<td>15. Chronic Uveitis</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Glaucoma</td>
<td>1 2 3 4 5</td>
<td></td>
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</tr>
</tbody>
</table>
17. Progressive/End stage/Secondary glaucoma 1 2 3 4 5
18. Diabetic retinopathy 1 2 3 4 5
19. Diabetic macular edema 1 2 3 4 5
20. Retinal occlusive disease 1 2 3 4 5
21. Hypertensive retinopathy 1 2 3 4 5
22. Cataracts 1 2 3 4 5

Management of ocular anomalies associated with…
23. Diabetes 1 2 3 4 5
24. Auto-immune disorders 1 2 3 4 5
25. Hypertension 1 2 3 4 5
26. Cardiovascular disorders 1 2 3 4 5
27. HIV 1 2 3 4 5

Knowledge and application of current scientific literature to…
28. Diagnostic protocols 1 2 3 4 5
29. Management 1 2 3 4 5

Communication of …
30. Diagnosis and management of complex or unusual conditions to patients 1 2 3 4 5
31. Appropriate information in written and/or oral format to referring optometrist or physicians 1 2 3 4 5
32. Appropriate information when referring a patient to a medical specialist 1 2 3 4 5
33. Optometric knowledge in a formal format (e.g., lecture) to students, optometrist, or other professionals 1 2 3 4 5

What do you consider your strengths?

Areas of skills/knowledge requiring the greatest development?
Please indicate your level of interest in each of the following areas on a scale of 1 to 5. 1 = not at all interested, 5 = very interested.

1) Clinical Interests
   a) General (primary care) optometry
   b) Ocular pathology
   c) Contact Lenses
   d) Management of Binocular Vision Anomalies
   e) Pre-school Pediatrics
   f) School age Pediatrics
   g) Geriatrics
   h) Vision Rehabilitation
   i) Other ____________________________

2) Teaching Interests
   a) Clinical Attending
   b) Lab instructor
   c) Lecturer (opt. students)
   d) Lecturer (cont. education to O.D.s)
   e) Other ____________________________

3) External Clinical Rotations
   a) Vision Screenings
   b) Multidisciplinary Rotations
   c) Eye Surgery Observation
   d) Ophthalmology Sub-Specialty
   e) Optometry “Specialty”
   f) Other ____________________________

4) Research Interests
   a) Basic Research
   b) Clinical Research
   c) Case Reports
   d) Other ____________________________

- Do you have any ideas for research projects that you would like to do this year?
- Would you be interested in presenting a research paper or case report at a national meeting?
- What are some of your goals for this residency year?

- What are your goals for the year after you have completed the residency program?

- What are your goals for five years from now?

- Literature Review Interest

- Please list any topics that you would like to read about and discuss in the literature review sessions.

- Additional suggestions or comments.
Family Practice Residency Self Assessment

Resident’s Name: ____________________________
Date: __________________

The purpose of this form is to allow you to rate your skills, knowledge and experience in variety of areas important to primary eye care and for you and your Program Coordinator to track your development throughout your residency. Please indicate how comfortable you feel in performing and interpreting the results of the following procedures on a scale of 1-5:

1 = Unfamiliar with the procedure
2 = Have read or heard about the procedure but have not performed it
3 = Somewhat comfortable with the procedure and have performed it a few times
4 = Reasonably comfortable with the procedure and have performed it several times
5 = Very comfortable with the procedure and have performed it extensively.

1. Ocular and adnexal health evaluation utilizing routine ophthalmic instrumentation and procedures (including SL examination, SL fundus lens and BIO) with interpretation.

2. Determination of refractive and binocular vision status

3. Practicing evidence-based medicine

4. Emergency care of ocular and adnexal conditions; including on-call duties.

5. Diagnosing and managing binocular vision disorders.
   a. Strabismic
   b. Non-strabismic

6. Diagnosing neuro-ophthalmic conditions

7. Managing the low vision patient

8. Contact lens management
   a. SCL
   b. SCL Toric
   c. Monovision
   d. GP

9. Cataract co-management

10. Refractive surgery co-management

11. Diagnosis and management of:
   a. Retinal pathology.
   b. Ocular complications of systemic disease.
   c. Conjunctival pathology.
   d. Lids and adnexa.
   e. Lens
   f. Glaucoma

12. Diagnosis and management of corneal pathology

13. Ordering and interpretation of ocular photography

□ Pre-Residency
□ Mid-Residency
□ Post-residency
14. Visual field interpretation
15. Gonioscopy
   a. Procedure
   b. Interpretation
   c. Recording
16. NFLA (GDx, HRT, OCT):
   a. ordering
   b. Interpretation
17. Pachymetry
18. Specular Microscopy
   a. Ordering
   b. Interpretation
19. Scleral Depression
20. Foreign body removal
21. Epilation of lashes
22. Expression of adnexal glands
23. Prescribing topical and diagnostic pharmaceutical agents
   a. Glaucoma
   b. Anterior seg disease: infectious
   c. Uveitis/ iritis
   d. Ocular allergies
   e. Dry eye
24. Prescribing oral pharmaceutical agents
25. Ordering and interpretation of diagnostic laboratory studies for anterior segment disease.
26. Communicating with other health professions – written and oral
   (e.g., referrals, consultations)
27. Oral presentation to health professionals/students

Identify three or more areas where your skills/knowledge/experience requires the most development.

1.
2.
3.

Residency Supervisor: _____________________________  Date: ____________________________
Low Vision Rehabilitation Residency Self Assessment

□ Pre-Residency  □ Mid-Residency  □ Post-residency

Resident’s Name: ____________________________
Date: __________________

The purpose of this form is to allow you to rate your skills, knowledge and experience in variety of areas important to low vision rehabilitation and for you and your Program Coordinator to track your development throughout your residency. 1 = skills, knowledge and experience of an entry level optometrist (new graduate) and 5 = those of an expert/post residency trained optometrist.

1. Communicating/interaction with a visually impaired or blind adult 1 2 3 4 5
2. Communicating/interacting with visually impaired or blind child 1 2 3 4 5
3. Communicating “bad” news (e.g., driving, progressive vision loss) 1 2 3 4 5
4. Educating patients and including them in decision making 1 2 3 4 5
5. LV history intake: (knowing all the components to be addressed)
   a. Ocular/medical hx 1 2 3 4 5
   b. Ocular hx as it relates to visual function or lack of 1 2 3 4 5
   c. Presence of support for vision rehabilitation 1 2 3 4 5
   d. Presents of co-morbidities and its effect on LV rehab 1 2 3 4 5
6. Determining patient’s main goal 1 2 3 4 5
7. Determining magnification for distance 1 2 3 4 5
8. Determining magnification for near reading 1 2 3 4 5
9. Determining optimal option(s) of optical delivery 1 2 3 4 5
10. Prescribing custom-designed systems for magnification /field enhancement 1 2 3 4 5
11. Utilizing filter/tints to enhance visual function/comfort 1 2 3 4 5
12. Determining computer/electronic needs 1 2 3 4 5
13. Devices and training for driving 1 2 3 4 5
14. Managing visual field loss (e.g., optical, training, referral) 1 2 3 4 5
15. Training eccentric viewing skills 1 2 3 4 5
16. Practicing evidence-based medicine 1 2 3 4 5
17. Knowledge of billing and coding for low vision 1 2 3 4 5
18. Communicating with other health professions – written and oral (e.g., referrals, consultations) 1 2 3 4 5
19. Oral presentation to health professionals/students 1 2 3 4 5

Identify three or more areas where your skills/knowledge/experience require the most development.
1.  
2.  
3.  

- 44 -
The purpose of this form is to allow you to rate your knowledge, skills, and experience in areas related to the diagnosis and management of ocular disease. You will complete this assessment at the beginning and end of the program. The form will help you and your Program Coordinator track your development throughout your residency. Please indicate your confidence using the scale below:

0 = No experience with a patient/ unfamiliar with condition or procedure
1 = Limited experience/ not confident with condition or procedure
2 =
3 = Moderate experience/ moderate confidence
4 =
5 = Extensive experience / very high level of confidence

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<tr>
<th>Procedures/Tests:</th>
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<th>Interpret</th>
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<tbody>
<tr>
<td>1. ocular/adnexal health evaluation utilizing routine ophthalmic instrumentation (SL, BIO, +78D fundus evaluation)</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>2. Pachymetry</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>3. Gonioscopy</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>4. Automated visual fields</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>5. OCT – Retina</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>6. OCT – Retinal nerve fiber layer</td>
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<td>7. GDx</td>
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<td>8. B-scan ultrasonography</td>
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<td>9. Fundus photography</td>
<td>0 1 2 3 4 5</td>
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<td>10. Fluorescein angiography</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
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<td>11. Scleral depression</td>
<td>0 1 2 3 4 5</td>
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<td>12. Specular microscopy</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
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<tr>
<td>13. Foreign body removal (cornea or conjunctiva)</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
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<td>14. Epilation of eyelashes</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
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<tr>
<td>15. Culturing (cornea or conjunctiva)</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
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<td>Diagnosis</td>
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<td>Management</td>
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<td>Blepharitis</td>
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<td>Conjunctivitis</td>
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<td>Corneal dystrophies/degenerations</td>
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<td>Infectious keratitis</td>
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<td>fungal</td>
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<tr>
<td>Uveitis</td>
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<tr>
<td>Lens anomalies/cataract</td>
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<td>Glaucoma - chronic</td>
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<td>Glaucoma – acute</td>
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<tr>
<td>Diabetic retinopathy - staging</td>
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<td>Diabetic macular edema</td>
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<td>Retinal vascular occlusive disease</td>
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<td>Hypertensive retinopathy</td>
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<td>Age-related macular degeneration</td>
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<tr>
<td>Optic nerve anomalies other than glaucoma</td>
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</tbody>
</table>

**Prescribing topical pharmaceutical agents for:**

1. anterior segment – inflammation                                       | 012345    |
2. anterior segment – infection                                           | 012345    |
3. ocular allergies                                                       | 012345    |
4. dry eye                                                                | 012345    |
5. glaucoma                                                               | 012345    |
Prescribing oral pharmaceutical agents for:

1. anterior segment – infection 0 1 2 3 4 5
2. allergy 0 1 2 3 4 5
3. dry eye 0 1 2 3 4 5
4. glaucoma 0 1 2 3 4 5

Ordering and interpreting laboratory tests for:

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<thead>
<tr>
<th></th>
<th>Order</th>
<th>Interpret</th>
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<tr>
<td>1. systemic disease (ex: diabetes)</td>
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<td>0 1 2 3 4 5</td>
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<tr>
<td>2. uveitis</td>
<td>0 1 2 3 4 5</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>3. neurologic (ex: giant cell arteritis)</td>
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<td>0 1 2 3 4 5</td>
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<tr>
<td>4. neurologic imaging studies</td>
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</tr>
</tbody>
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Application of current scientific literature to:

1. diagnosis of ocular disease 0 1 2 3 4 5
2. management of ocular disease 0 1 2 3 4 5

Communication

1. Diagnosis/explanation of conditions to patients 0 1 2 3 4 5
2. Written/oral communication with other optometrists or physicians 0 1 2 3 4 5
3. Oral presentation (seminar, lecture) to optometrists or optometry students 0 1 2 3 4 5

What do you consider your strengths?
1.
2.
3.

In which areas do you require the most development?
1.
2.
3.
UHCO Pediatric Resident Initial Self Evaluation

Name of Resident: ________________________
Date of Evaluation: ______________________

Approximately how many patients in each category below did you see as an optometry student:
- Infants (0-18 mos): __________
- Toddlers (19-36 mos): __________
- Preschoolers (3-5 yrs): __________
- School age kids (6-17yrs): __________
- Nonstrabismic BV/Accom disorders: __________
- Strabismic disorders: __________
- Amblyopes: __________
- VPS & learning related disorders: __________
- Special needs/multiply impaired: __________
- Brain injury/stroke/neurologic disorders: __________

How confident are you with your **knowledge** in the following areas?

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<tr>
<th></th>
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<th>Moderately Confident</th>
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<td>Common ocular pathology as related to emergency on-call</td>
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<td>Ancillary diagnostic tests (i.e. GDX, OCT, HRT, automated VF)</td>
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<td>Prescribing ocular and systemic medications for ocular problems</td>
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How confident are you with the following **diagnostic skills**?

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- 48 -
- Full HPI related to strabismus 0 1 2 3 4 5
- Informal assessment of VA and how to document (RTO, F&F) 0 1 2 3 4 5
- Object acuity calculations (determining VA based on object size and test distance viewed) 0 1 2 3 4 5
- 2 alternative forced choice acuity testing (i.e. TAC, Cardiff) 0 1 2 3 4 5
- Preschool VA testing (i.e. Lea, HOTV) 0 1 2 3 4 5
- Bailey-Lovie VA testing & logMar calculations 0 1 2 3 4 5
- Preschool Contrast Sensitivity testing (i.e. Hiding Heidi) 0 1 2 3 4 5
- Retinoscopy (especially loose lens) & prescribing directly from results 0 1 2 3 4 5
- MEM retinoscopy 0 1 2 3 4 5
- Cover test, Hirshberg, Krimsky 0 1 2 3 4 5
- Comitancy testing (including Park’s 3 step) 0 1 2 3 4 5
- Double Maddox rod evaluation of torsion 0 1 2 3 4 5
- Visuoscropy evaluation of eccentric fixation 0 1 2 3 4 5
- Retinal correspondence assessment 0 1 2 3 4 5
- Preschool stereo tests (Lang, Preschool Randot, Frisby) 0 1 2 3 4 5
- Objective vergence assessment (prism bars, etc) 0 1 2 3 4 5
- Associated phoria testing (Wesson, vectographic slide) 0 1 2 3 4 5
- Denver Developmental Test 0 1 2 3 4 5
- Visual perceptual skills tests (SASP, Rutgers, VMI, TVPS) 0 1 2 3 4 5
- Auditory perceptual skills tests (PASP) 0 1 2 3 4 5
- Other learning based tests (i.e. IAI, WRAT, IQ) 0 1 2 3 4 5
- Toponopen IOP measurements 0 1 2 3 4 5
- Hand held slit lamp 0 1 2 3 4 5
- Ocular health eval of infants, toddlers, preschoolers 0 1 2 3 4 5
- Anterior segment evaluation as it relates to emergency red eyes 0 1 2 3 4 5
- Foreign body removal of the anterior segment 0 1 2 3 4 5
- Gonioscopy evaluation of the anterior chamber angle 0 1 2 3 4 5
- Scleral depression for suspected retinal holes, tears, detachments 0 1 2 3 4 5

How confident are you with diagnosing the following conditions?

| Nonstrabismic BV/Accom disorders | 0 1 2 3 4 5 |
| Strabismus | 0 1 2 3 4 5 |
| Amblyopia | 0 1 2 3 4 5 |
| Cranial nerve palsies | 0 1 2 3 4 5 |
| Developmental/perceptual delays | 0 1 2 3 4 5 |
| Nystagmus | 0 1 2 3 4 5 |
| Visual impairment: cortical & other congenital/early onset disorders (i.e. Optic nerve hypoplasia, Leber’s) | 0 1 2 3 4 5 |
| Visual/ocular disorders of preterm infants | 0 1 2 3 4 5 |

- Visual/ocular disorders of special needs patients 0 1 2 3 4 5
  - List the disorders you are aware of:

- Visual/ocular disorders of brain injury/stroke patients 0 1 2 3 4 5
  - List the disorders you are aware of:

- Pediatric ocular pathology 0 1 2 3 4 5
- Ocular urgencies/emergencies 0 1 2 3 4 5
How confident are you with the following management options?

<table>
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<tr>
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- Prescribing glasses for infants, toddlers, preschoolers considering normal development of RE, VA, and BV anomalies? 0 1 2 3 4 5
- Prescribing best sensory Rx for BV/Accom disorders including adds 0 1 2 3 4 5
- Prescribing prism for BV disorders 0 1 2 3 4 5
- Designing and implementing vision therapy plans for nonstrabismic BV/Accom disorders 0 1 2 3 4 5
- Using computer orthoptic programs for VT:
  - HTS vergence therapy program 0 1 2 3 4 5
  - HTS amblyopia therapy program 0 1 2 3 4 5
- Determining whether strabismus would be best managed by observation, glasses (RE, add, prism), VT, and/or surgery 0 1 2 3 4 5
- Designing and implementing VT plans for strabismic disorders 0 1 2 3 4 5
- Prescribing amblyopia therapy
  - Patching 0 1 2 3 4 5
  - Atropine 0 1 2 3 4 5
  - Active VT (monoc and binoc) 0 1 2 3 4 5
- Prescribing VPS/Developmental therapy 0 1 2 3 4 5
- Making functional recommendations to parents & teachers for special needs patients 0 1 2 3 4 5
- Making functional recommendations to teachers for the visually impaired & special ed teachers for visually impaired patients 0 1 2 3 4 5
- Managing visual disorders of brain injury/stroke patients 0 1 2 3 4 5
- Your ability to understand and apply current scientific literature into patient care through evidence based clinical decision making? 0 1 2 3 4 5

Other:

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  - Optometrists 0 1 2 3 4 5
  - Ophthalmologists 0 1 2 3 4 5
  - Pediatricians/Physicians 0 1 2 3 4 5
- How do you rank your formal presentation skills (e.g. lectures, presentations) to:
  - Optometry students 0 1 2 3 4 5
  - Optometrists 0 1 2 3 4 5
  - Other professionals 0 1 2 3 4 5
- How confident are you in your ability to continually improve your patient care through self-assessment and quality assurance evaluations: 0 1 2 3 4 5
Approximately how many patients in each category below did you see as an optometry resident: (will get information from patient log)

- Infants (0-18 mos):
- Toddlers (19-36 mos):
- Preschoolers (3-5 yrs):
- School age kids (6-17yrs):
- Nonstrabismic BV/Accom disorders:
- Strabismic disorders:
- Amblyopes:
- VPS & learning related disorders:
- Special needs/multiply impaired:
- Brain injury/stroke/neurologic disorders:

How confident are you with your knowledge in the following areas?

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How confident are you with the following diagnostic skills?

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How confident are you with diagnosing the following conditions?

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- 52 -
How confident are you with the following management options?

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- Prescribing amblyopia therapy
  - Patching 0 1 2 3 4 5
  - Atropine 0 1 2 3 4 5
  - Active VT (monoc and binoc) 0 1 2 3 4 5
- Prescribing VPS/Developmental therapy 0 1 2 3 4 5
- Making functional recommendations to parents & teachers for special needs patients 0 1 2 3 4 5
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- Your ability to understand and apply current scientific literature into patient care through evidence based clinical decision making? 0 1 2 3 4 5

Other:

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  - Optometrists 0 1 2 3 4 5
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  - Pediatricians/Physicians 0 1 2 3 4 5

- How do you rank your formal presentation skills (e.g. lectures, presentations) to:
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  - Optometrists 0 1 2 3 4 5
  - Other professionals 0 1 2 3 4 5

- How confident are you in your ability to continually improve your patient care through self-assessment and quality assurance evaluations: 0 1 2 3 4 5
MEDICAL RECORDS

1. Electronic medical records (EMRs), OfficeMate, are used in all Services at UHCO, CASA, Good Neighbor, and San Jose Clinics.

2. EMRs, preferably, should be finalized the same day but no later than 7 days from the date of the examination. Residents should not finalize charts prior to licensure. After licensure, in many cases charts for patients with third party billing will require a faculty signature and the faculty will finalize the EMR.

3. Scanning stations are located in each service to scan documents or previous patient charts.

4. Program Coordinators will periodically perform a chart review and quality assurance.

5. Each resident will receive a username and password for OfficeMate. When logging in select the Service where you are seeing patients, then select the appropriate template for the Service. If you select the incorrect Service the document cannot be transferred. All data must be re-entered for the appropriate Service.

6. Training for OfficeMate will be provided/arranged by the Residency Program Coordinator as each service has a unique template.

A medical record is a legal document that should be sufficiently detailed and contain all significant clinical information pertaining to the patient. Clinic records of patients treated at the College of Optometry are the property of the University Eye Institute and are not to be removed or reproduced without proper authorization or in accordance with a subpoena, court order, or statute.

Unauthorized removal of patient records from the Clinic/College is grounds for suspension.

A Medical Record shall be maintained for every individual who is evaluated or treated at the University Eye Institute, the University Eye Institutes External Clinics, or by a University Eye Institute doctor, technician, or optician.

Currently the Medical Record is considered a hybrid record, consisting of both electronic and paper documentation if the patient was provided services prior to EMR implementation. NOTE: paper charts for patients who have not been examined at the UEI for 3 years have been purged and are stored offsite. It can take up two weeks to obtain these records. Some paper records have been scanned into the EMR, but most have not.

The clinic record serves several purposes. It is used to:
1. Document the course of the patient's treatment,
2. Communicate between the doctors and other professionals contributing to patient care,
3. Provide continuity of care on subsequent visits by the patient,
4. Review, study, and evaluate patient care by clinic or faculty/staff committees,
5. Provide data for: third parties concerned with the patients; other doctors and health care facilities; insurance companies; compensation carriers; attorneys; government agencies,
6. Provide data to assist in protecting the legal interest of the patient, the University Eye Institute, faculty/staff,
7. Provide data for research, study, and education.

Guidelines for Medical Record Documentation
The following are important guidelines for health professionals because they preserve the integrity of a clinical record. Without the cooperation of all personnel, the accuracy of the records may suffer.

1. The patient's name and clinic folder number must be clearly visible on every form generated for the record. Without this proper identification, the data is unidentifiable.
2. All entries on the medical record must be dated on the day the entry is made and signed by the responsible individual. These entries must be written in black or dark blue ink to photocopy or microfilm satisfactorily.
3. Erasures and other alterations of the record must be avoided. To correct an error, rule lightly through the error so that it can be easily read. All corrections must be initialed and dated by the person making the correction.

Processing a Clinical Record
Students should attempt to complete the EMR the day of the patient’s visit. However, the deadline for completion is no later than 24 hours of the patient’s scheduled examination.

Resident must complete the EMR within 7 days, but within 24 hours is preferred.

Failure to comply within this period will constitute a breech of policy as set forth by the Clinic Council and will be addressed by the Executive Director of the UEI.

Quality Review of Record Documentation
In order to maintain consistent, comprehensive record documentation, records completed by residents are reviewed routinely by the Residency Program Coordinator for content and completeness. Deficiencies are monitored and corrective measures will be directed, as needed.

Release of Information
The patient is entitled to the protection of his/her personal and medical information. All patient care information is regarded as confidential and is available only to authorized users.

Due to the varied nature of the requests and the desire to provide the best continuation of care for the patient, all requests received by the Medical Record Department for patient information will be referred to the appropriate doctor or Service Coordinator for processing. The clinic record will be pulled and delivered to the Service along with the written request and authorization if one is provided.

Requests made by telephone will also be referred to the appropriate Service with available information to aid in making the return call.

Authorization for Release of Information
A valid authorization for release of information should contain:

1. Name of the institution that is to release the information.
2. Name of the individual/institution to receive the information.
3. Patient identification to include full name, address, and date of birth.
4. Purpose or need for the information.
5. Extent or nature of the information to be released (inclusive date of treatment).
6. Date that consent is signed.
7. Signature of patient or the patient's legal representative.

A legible photocopy of an authorization is considered valid. The release must be scanned and attached to the EMR.

**Parental Rights**

A parent does not automatically have the right to a minor child’s medical records. The HIPAA Privacy Rule generally allows parents to have access to their children’s medical records. However, there are four situations that you should be aware of when this is not the case:

- If the minor is the one who consented to care and the State or other applicable law does not require parental consent. Texas requires parental/guardian consent for the medical and eye care services that the UEI provides to minors;
- If the minor obtains care at the direction of a court or a person appointed by the court;
- If the minor child has been emancipated (released from parental control and supervision) in a court of law; or,
- If the parent agreed prior to the care that the minor and the health care provider would have a confidential relationship.

Even if a particular situation does not fall into one of the four exceptions, a treating physician may use professional judgment on whether to allow a parent access to a minor’s medical information. Refusing a parent access usually only happens when the physician believes that the minor has been or may be subjected to domestic violence, abuse, or neglect. In other words, the physician believes that treating the parent as the minor child’s personal representative could endanger the child.
Authorization For Release Of Information

UNIVERSITY of HOUSTON, COLLEGE of OPTOMETRY
505 J. Davis Armistead Building
Houston, TX 77204-2020
Medical Records Department (713) 743-1922
Medical Records Facsimile (713) 743-0963

TO:  Physician/Clinic: _________________________________________________
Address: _____________________________________________________________________
Phone Number: _________________________Facsimile Number:______________________

1. I hereby request and authorize the release of information from the health record(s) of:

Patient’s Name _______________________________ Patient’s Date of Birth _______________________________

Patient’s Record Number (if known) _______________ Patient’s Social Security Number _______________

_____________________________ ________________
Patient’s Phone Number Patient’s Facsimile Number

2. I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any condition.

3. The requested information is to be sent to: University of Houston, College of Optometry
Attention: _______________________________
505 J. Davis Armistead Building
Houston, TX 77204-2020

4. The information to be released is and the records to be sent include:

All Records: ___________ Prescription Only: ________________ Other: _________________________________

5. Purpose/reason for release of records (circle): Medicare Insurance Legal Matters Research
Other (explain) __________________________________________________________________________.

6. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.

7. I understand that my treatment is not conditioned on obtaining this authorization.

8. I understand that this authorization is specific for release only to the above party and expires (90) days following the date of signature.

9. I understand that information used or disclosed may no longer be protected by federal privacy laws.

10. I understand that I can be charged for obtaining copies of my records according to the fee schedule established in the Texas Administrative Code.

Printed Name of Patient: ____________________________________ Date: ________________
Signature of Patient: _______________________________________________________________________
Printed Name of Patient’s Representative: _________________________________________________
Signature of Patient’s Representative: _____________________________________________________
Relationship to Patient: _____________________________________________________________________
Authorization For Release Of Information

UNIVERSITY of HOUSTON, COLLEGE of OPTOMETRY
505 J. Davis Armistead Building
Houston, TX 77204-2020
Medical Records Department (713) 743-1922
Medical Records Facsimile (713) 743-0963

1. I hereby request and authorize the University of Houston, College of Optometry to release information from the health record(s) of:

__________________________________________________________________________  __________________________
Patient’s Name  Patient’s Date of Birth

__________________________________________________________________________  __________________________
Patient’s Record Number (if known)  Patient’s Social Security Number

__________________________________________________________________________  __________________________
Patient’s Phone Number  Patient’s Facsimile Number

2. I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any condition.

3. The requested information is to be sent to (name of doctor, hospital, person, or organization where records should be sent):

Name: __________________________________________

Address: ________________________________________________________________

City: _______________________________ State: _____________ Zip Code__________

Phone: _________________________ Facsimile Number: ________________________

4. The information to be released is and the records to be sent include:

All Records: __________  Prescription Only: __________  Other: ____________________________

5. Purpose/reason for release of records (circle): Medicare  Insurance  Legal Matters  Research

Other (explain) __________________________________________________________________________.

6. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.

7. I understand that my treatment is not conditioned on obtaining this authorization.

8. I understand that this authorization is specific for release only to the above party and expires (90) days following the date of signature.

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10. I understand that I can be charged for obtaining copies of my records according to the fee schedule established in the Texas Administrative Code.

Printed Name of Patient: ____________________________ Date: __________________________

Signature of Patient: _______________________________________________________________________

Printed Name of Patient’s Representative: _____________________________________________________

Signature of Patient’s Representative: ______________________________________________________________________

Relationship to Patient: ____________________________________________________________________
University Eye Institute Notice of Privacy Practices
The current privacy notice is located in the UEI Student Policies Manual on the intranet. The URL is http://intranet.opt.uh.edu/student/UEI-Student-Policies.pdf
MEDICAL RECORDS GUIDELINES

The Harris County Medical Society has prepared for physicians the following guidelines on patient medical records. The information has been taken from several publications in an attempt to provide physicians with a simple and condensed reference on the subject.

Specific questions or legal advice should be obtained from the physician's attorney, the Office of the General Counsel of the Texas Medical Association 1-800-880-1300, X1340, or X1341, or the attorney for the carrier of your professional liability insurance.

(This document was updated in July, 1996)

1. Is a physician obligated to forward to another physician the medical records of a former patient? A physician who formerly treated a patient should not refuse, for any reason, to make his records of that patient promptly available on request to another physician presently treating the patient. Proper authorization for the use of records must be granted by the patient.

2. Should a physician obtain a written release from a patient before releasing medical records? Proper authorization for the use of records must be granted by the patient. Before releasing medical records, the physician must receive from the patient a signed, written authorization which states (1) the records which are to be covered by the release, (2) the reasons or purposes for the release, and (3) the person to whom records are to be released.

   The record is a confidential document involving the physician-patient relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community.

3. What is included by the term "medical records"? Medical records mean any records pertaining to the identity, diagnosis, evaluation, or treatment of a patient by a physician that are created or maintained by a physician.

4. Who owns a patient's medical records? Notes made in treating a patient are primarily for the physician's own use and constitute his/her personal property. However, a physician shall furnish (1) copies of medical records, (2) a summary or (3) a narrative report of the medical records, pursuant to a written consent for release of the information.

5. May the physician charge a fee for the time and expense involved in forwarding this information? The physician shall furnish the information within a reasonable period of time and may charge reasonable fees for furnishing the information to be paid by the patient or someone on his behalf.

6. Is a physician obligated to forward medical records to an attorney -- or anyone other than the patient -- without a subpoena? On proper written authorization from the patient, a physician should provide a copy or a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient.

7. Are there situations when it would be appropriate for a physician to legally refuse release of records? Texas law provides that a physician may refuse to release medical records if the physician determines that access to the information would be harmful to the physical, mental, or emotional health of the patient. Please note that a physician may delete confidential information about another person who has not consented to the release.

8. What should a physician do with patients' records upon retirement or relocation? If the physician is leaving his practice for any reason (retirement, relocation, etc.) patients should be
notified that copies of their records will be made available to them or to another physician if they provide the signed, written authorization described above.

9 **Is it legal for a physician to sell his practice?** It is both legal and ethical to sell a medical practice. However, the purchaser must agree to make records of any patient treated by the selling physician available to subsequent physicians, or to other persons the patients' designate. If a physician is selling his medical practice, he may wish to duplicate all files to be maintained in his possession to provide information in the future and to aid in his defense should he be sued. If such duplication is prohibitive in terms of expense, then he may wish to enter into an agreement with the physician purchasing his practice to maintain the records.

Patients may designate the recipient of their records -- even if it is the patient himself. In any event, the physician should send a copy of the records to the physician or patient and maintain the original records in his possession.

10 **How long should a physician keep patient records?** The statute of limitations of liability suits is two years for adults; however, the courts have created various exceptions. Therefore, it is suggested that the physician maintain the records for a greater length of time -- perhaps 10 years. This provides additional time for those injuries which may not be discoverable (injuries as a result of foreign objects left in the body, vasectomies, fraudulent concealment, radiation treatment, etc.) within the two year limitations period. The medical records for care provided to minors should be retained at least until the minor's 20th birthday, i.e., age 18 plus two years. A physician may wish to check with his/her professional liability insurance carrier to determine if the carrier has recommendations regarding a retention period for medical records.

11 **May a physician refuse to forward medical records if a patient has an outstanding bill?** It is unethical for a physician to refuse or to delay improperly in responding to a valid request for transfer of a former patient's medical records because of an unpaid bill.

12 **Is a physician obligated to forward the information if an attorney calls and requests medical records on a patient who is suing that physician or that physician's colleague(s)?** A patient is entitled to obtain complete and unaltered copies of his medical records from the physician he/she is suing. Therefore, if a patient's attorney who is suing a physician requests records, that physician should comply with the request with proper written authorization from the patient and after notifying his professional liability insurance company. If a patient's attorney who is suing a colleague requests medical records, the physician should comply with the request after being provided with a written authorization from the patient.

13 **Do the same general rules apply to retention of records on a deceased patient?** It is suggested that all adult records be kept 10 years whether the patient is deceased or not.

14 **What should a physician do if his office is served with a subpoena for medical records?** The physician should call the patient or patient's attorney and state that he has been served with a subpoena for that patient's records. The physician should then ask for the attorney or the patient to supply him with a written authorization releasing those records. Following this procedure assures that the patient will not later claim that the subpoena was defective and that the physician released confidential information. If a patient's attorney does not want the records released, he/she should move the court to quash the subpoena so that the physician will not have to reveal the medical records.
A brochure on this subject is available through the Texas Medical Association. Titled "Code for Physician and Attorneys of Texas," the brochure was developed by the TMA Committee on Liaison with the State Bar of Texas and the State Bar Committee on Coordination with other professional groups and is designed to achieve a better understanding between the medical and legal professions.

This condensed information contains quotations from the Medical Practice Act of Texas, the Current Opinions of the Texas Medical Association Board of Councilors (November 1986), and Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (1986).

Also referenced in the preparation of this publication were "Medicine and the Law" articles in Texas Medicine, "Medical Records—Retention and Release" (October 1983) and "Is there a statute of limitations in a medical professional liability lawsuit?" (April 1987).

(Update: July, 1996)

The Texas State Board of Medical Examiners (TSBME) has approved fees that physicians may charge for providing patients with copies of their medical records. The fees are $25 for the first 20 pages and 15 cents per page thereafter, plus the cost of mailing, shipping, or delivery.

Amendments to the Medical Practice Act of Texas adopted by the Texas Legislature last year define medical records as “any records pertaining to the history, diagnosis, treatment or prognosis of the patient, including copies of medical records of other health-care practitioners contained in the records of the physician to whom a request for release of records has been made.” The amendments provide that:

1. Physicians shall furnish copies or a summary of the records within 30 days after receiving a written request unless he or she determines that access to the information would be harmful to the patient’s physical, mental, or emotional health. The physician may delete confidential information about another person who has not consented to the release.

2. If the request is denied, either in whole or in part, the physician must give the patient a signed and dated written statement giving the reason for the denial and place a copy of it in the patient’s medical records.

3. Physicians may not charge for copies of records if the request comes from a licensed Texas health-care provider or physician licensed by any US state or territory or Canada for the purpose of emergency or acute medical care.

4. If a proper request is received for purposes other than emergency or acute care, the physician may withhold the records until payment is received. If payment is not made at the time of the request, the physician has 10 calendar days to notify the requesting party in writing of the need for payment, and a copy of the letter must be part of the patient’s file. Records cannot be withheld because of past-due accounts for medical care.

5. Physicians are not required to provide copies of billing records pertaining to a patient’s care unless specifically requested as part of the request for the release of medical records.

For more information, physicians may call TSBME at (512) 305-7065.
ASC Cataract Referrals

<table>
<thead>
<tr>
<th>Overview</th>
<th>ADL complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cataract referrals from any UEI Service to our ASC will now be</td>
<td>Must specifically state that a patient can no longer perform an activity.</td>
</tr>
<tr>
<td>made on-line. Once the referral is made, a demographic page will</td>
<td>• IE: Patient states they can no longer drive at night due to severe glare.</td>
</tr>
<tr>
<td>be processed and sent to surgical center staff. This process will be</td>
<td></td>
</tr>
<tr>
<td>the same for both insured and un-insured patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional Information</td>
</tr>
<tr>
<td></td>
<td>• Treat all pre-existing conditions <strong>prior</strong> to making your referral.</td>
</tr>
<tr>
<td></td>
<td>Including DES, blepharitis and glaucoma.</td>
</tr>
<tr>
<td></td>
<td>• For contact lens wearers: patient must remove SCL’s at least 1 week prior to</td>
</tr>
<tr>
<td></td>
<td>scheduling their pre op visit. If RGP’s, have patient remove lenses at least 2</td>
</tr>
<tr>
<td></td>
<td>weeks prior to pre-op visit.</td>
</tr>
<tr>
<td></td>
<td>• If you need additional space for clinical history or pictures, you may open</td>
</tr>
<tr>
<td></td>
<td>the PDF that is on the consult computers, fill it out and drag and drop into</td>
</tr>
<tr>
<td></td>
<td>the appropriate space on the form.</td>
</tr>
<tr>
<td></td>
<td>• Pre-op testing will be done at ECT for insured patients.</td>
</tr>
<tr>
<td></td>
<td>• Pre-op testing will be done in-house for un-insured patients.</td>
</tr>
</tbody>
</table>

All post op care will be done in-house.

<table>
<thead>
<tr>
<th>Instructions</th>
<th>Required Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loaded on the consult room computers is an icon labeled “cataract referral”</td>
<td>The following information has been requested by the ECT and needs to be included for</td>
</tr>
<tr>
<td>Double click the icon to bring up the referral form. Please choose an ECT</td>
<td>all cataract referrals.</td>
</tr>
<tr>
<td>doctor, Wade or Mayo for insured cataract patients; leave this blank if it</td>
<td>1. Activity of daily living (ADL) complaint: must specifically state an activity the</td>
</tr>
<tr>
<td>is an uninsured patient. Our surgeons for the un-insured will be either Dr.</td>
<td>patient can no longer do or feels un-comfortable doing because of their cataract.</td>
</tr>
<tr>
<td>Cross or Sanders. If you have a surgeon preference for these patients, type</td>
<td>It CANNOT simply be a statement of blur.</td>
</tr>
<tr>
<td>it in under the reason for the consult section on the form.</td>
<td>2. Clinical History: include all pertinent history information including current</td>
</tr>
<tr>
<td></td>
<td>medication use. Additionally, include SLE findings and DFE results including CD</td>
</tr>
<tr>
<td></td>
<td>assessment in this section. If you feel this patient should not be considered for a</td>
</tr>
<tr>
<td></td>
<td>premium IOL please state that.</td>
</tr>
<tr>
<td></td>
<td>3. Uncorrected and best corrected VA’s with refraction</td>
</tr>
<tr>
<td></td>
<td>4. IOP</td>
</tr>
<tr>
<td></td>
<td>5. Current CL wear</td>
</tr>
<tr>
<td></td>
<td>6. Does patient currently remove or has ever removed their glasses to read?</td>
</tr>
<tr>
<td></td>
<td>7. IOL discussion</td>
</tr>
</tbody>
</table>
Infection Control Recommendations

The UEI Infection Control Document is located in the Appendix.

The following guidelines are approved by the Clinic Faculty Executive Committee for the prevention of infectious diseases within the University Eye Institute. These guidelines are effective against all infectious agents likely to be encountered in the optometric practice, regardless of virility. While much concern has been raised about the virus that causes Acquired Immunodeficiency Syndrome (AIDS), the viral agents of epidemic keratoconjunctivitis, though not life threatening, are much more contagious. Therefore, proper controls for the latter will be adequate for the former. The known presence of an infectious agent always encourages precaution. It is the unknown presence of an infectious agent that brings the greatest risk; therefore, the recommended guidelines should be followed at all times.

1. Hand washing is an absolute must before and after any patient care procedure. Hand washing in front of the patient lets your patient know that you practice good hygiene.

2. Latex examination gloves should be worn to protect chapped hands or breaks in your skin from contact with body fluids such as blood, tears, mucous membranes or saliva. Examination gloves should also be worn anytime you or your patient has any infectious agent which may be transmitted as a result of the skin of your hands being compromised. Gloves do not replace hand washing. If the gloves are powdered, hand (glove) washing should be done before touching the patient about the eyes or handling contact lenses. DO NOT move around or leave the examination room while still wearing gloves. Wash your hands after removing examination gloves.

3. In performing blood glucose testing or venipuncture always wear latex examination gloves. The lancet or needle and syringe should be disposed of immediately into sharps boxes, without recapping.

4. All non-invasive instruments with which the patient has come into contact must be cleaned and disinfected with 70% isopropyl alcohol, zephiran (benzalkonium chloride), or other disinfectant as indicated. These instruments include, but are not limited to:
   a. The chin and forehead rests of all instruments.
   b. Phoropter/refractor face shields and forehead rests.
   c. Examination chair armrests and headrests.
   d. Visual field eyepatches (place a tissue underneath the patch).
   e. P.D. rulers.
   f. Occluders.
   g. Trial frame.
   h. Counter and table tops.
   i. Gonio lenses should be wiped with 70% isopropyl alcohol or zephiran, rinsed with water, cleaned with disinfecting soap, rinsed again with water, and dried with non-abrasive tissue or lens cloth.
   j. PMMA and RGP diagnostic contact lenses should be cleaned, rinsed with saline solution, disinfected in fresh 3% hydrogen peroxide for ten minutes, rinsed again in saline solution and dried for storage.
   k. Soft diagnostic contact lenses should be cleaned, rinsed with saline solution, disinfected in fresh 3% hydrogen peroxide, neutralized, and stored in sterile saline solution. Standard heat disinfection should be used for those lenses able to tolerate this procedure.
5. Instruments used for invasive procedures and minor surgery should be cleaned well with a disinfectant and prepared for autoclaving by placing them in autoclave bags.

6. Masks and gowns are generally not needed nor are they indicated for routine optometric procedures. If the patient is known to have an infection which may be transmitted by airborne routes, such as tuberculosis, etc., masks should be worn. The immunocompromised patient should be asked to wear a mask for their own protection. If the examiner has an infection transmitted by airborne routes, then he/she should be excused from the clinic until non infectious.

7. Any material contaminated with body fluids or blood, such as dirty gauze dressings and patches, should be properly disposed of in biohazard containers.

8. Clinic coats or clothing contaminated with blood or body fluids must be decontaminated by soaking in a solution of 1:10 chlorine bleach for 30 minutes prior to laundering.

9. Refer to the Infectious Control Program and Standard Operating Procedures document for other policies and procedures pertaining to control of biohazards.

10. Report all accidental exposures to the Chief of Medical Services. In addition, an accident report must be completed.

TONOMETER STERILIZATION

Background
1. Hepatitis C virus is the most common chronic blood borne infection in the US.
2. 20-40% of chronically infected Hepatitis C patients have no known risk factors for Hepatitis C infection.
3. 50% of Hepatitis C seropositive patients are currently ambulatory and asymptomatic.
4. Hepatitis C virus has been isolated from tear fluid and the concentration in the tears may be higher compared to plasma and is independent of the severity of Hepatitis C infection.
There is a potential and real possibility of transfer of Hepatitis C virus during the course of an eye examination.
5. An isopropyl alcohol wipe leaves 88.91% of Hepatitis C RNA remaining on tonometer tips.
6. Povidone iodine wipes kill over 99% of Hepatitis C virus.

Procedure
Before each measurement:
1. Get 2 tissues, one 10% povidone iodine packet, and one isopropyl alcohol packet.
2. Carefully open the iodine packet (they are pretty moist) being aware that iodine may stain anything (lab coats, shirts, chairs, instruments, carpets, etc.) it touches. Save the foil pack, placing it on top of one of the tissues. Gently wipe the tonometer tip for 5 seconds, then place the pad on the foil, wrapping all components in the tissue and then discard it in a trash receptacle.
3. Quickly wipe off any residue of iodine from the tonometer tip with the alcohol pad and gently dry with the other tissue. The probe is now ready for use.
4. Wash your hands before touching anything.

Do not irrigate the tonometer tips with saline or contact lens solutions. Moisture will enter the tonometer housing and cause permanent damage.
Emergency Procedures

An emergency is an unexpected, serious event demanding immediate attention. Fortunately, in our facility, true emergencies are a rare occasion; however, one must be prepared to act quickly if an emergency should arise. An emergency may be of ocular origin (i.e., central retinal artery occlusion, chemical burns of the cornea, bilateral papilledema swelling) or systemic in nature (i.e., chest pain, loss of consciousness).

In general, if an emergency occurs, the Chief of Medical Services should be summoned immediately. If feasible, the patient should be transported to the minor surgery/emergency room in the Medical Services area. If the patient cannot be safely moved, medical treatment must be provided at the original site.

Seizures

Seizures can result from a primary central nervous system disorder or may be a manifestation of a serious underlying metabolic or systemic disorder. Management of a seizure, whatever the etiology, is primarily limited to preventing bodily injury. Vital functions, such as respiration, must be monitored and supported. Attempts to protect the tongue should not generally be undertaken unless a padded tongue depressor or plastic airway can be inserted between the teeth easily. It is counterproductive to damage teeth, gums or tongue while trying to force an object between tightly clenched jaws. A finger should never be inserted into the patient’s mouth to straighten the tongue. This action is both dangerous and unnecessary. Clothing about the neck should be loosened and a pillow placed under the head. The patient should be rolled onto his side to prevent aspiration of vomitus. The patient should be monitored and CPR initiated if indicated. Once the patient is stable, he/she should be referred for a neurologic examination.

Syncope

Syncope is a sudden, brief, loss of consciousness and may result from a variety of cardiovascular and noncardiovascular causes. In the clinical setting, the most common type of syncope is the vasovagal disorder that is seen in all age groups and affects men and women equally. The common precipitating factors are emotional upset, sight of blood, painful medical procedures, injury, application of a contact lens, etc.

Physiological decreases in both arterial pressure and heart rate, mediated by the vagus nerve, combine to produce central nervous system hypoperfusion and subsequent syncope. Serious cerebral hypoxia with resultant tonic-clonic movements is more likely to occur if the patient remains upright. The patient may experience a prodrome lasting from 10 seconds to a few minutes and includes weakness, light-headedness, nausea, sweating, salivation, blurred vision, and tachycardia. Examination reveals an individual who is pale, sweating, has dilated pupils and a slow, weak pulse. With loss of consciousness, bradycardia replaces tachycardia. Abnormal movements may be noted during the period of unconsciousness. These movements are mainly tonic or opisthotonic but tonic-clonic activity is occasionally manifested. Urinary incontinence may occur, but tongue biting is rare.

Treatment of these patients includes recumbence, monitoring, reassurance and a recommendation to avoid precipitating factors. These measures are usually all that is necessary. Adequate nutrition and hydration should be encouraged. After a period of observation, the patient should be referred to their private physician to exclude cardiogenic syncope.
Chest Pain

There are many causes of chest pain that may be attributable to the heart, lung, esophagus, pancreas, gall bladder, and musculoskeletal systems. Clinically, it is often difficult to ascertain exactly what the problem may be. The clinical diagnosis of a typical myocardial infarction is based on a history of crushing chest pain or discomfort that lasts longer than 30 minutes, is not relieved by rest and has no other clear explanation. The pain often radiates to the neck or either arm. Other symptoms such as nausea, dyspnea, and profuse sweating are often present. Painless infarcts and atypical pain (e.g., pain in the jaw or either arm without chest pain) occur occasionally, especially in diabetic patients.

If you are with someone who is experiencing any of these symptoms, the first step is to have the victim rest quietly and calmly. Since both angina pectoris and heart attack are caused by too little oxygen to the heart muscle, the victim's activity must be kept to a minimum. The victim should be allowed to assume the position that gives him or her the most comfort and easiest breathing.

If prescribed by a physician, nitroglycerin placed under the tongue or an ointment placed on the skin may relieve the pain of angina pectoris. Since nitroglycerin lowers the blood pressure it should be given with the victim lying or sitting. It usually produces a stinging sensation under the tongue and may cause a headache. If cardiac symptoms persist for more than 5 to 7 minutes following rest and nitroglycerin, EMS should be activated. If a patient begins to experience cardiac arrest or failure, CPR should be initiated until emergency personnel arrive. When you telephone for help, tell the dispatcher:

1. You have a patient who needs immediate emergency care and give explicit instructions for reaching the front door of the Optometry building through U of H entrance #2.
2. The telephone number from which you are calling.
3. How many persons need help.
4. What the apparent problem seems to be.
5. The condition of the patient.
6. What is being done for the patient.

Always hang up last, allowing the dispatcher to hang up first. After summoning an ambulance, notify campus police (713-743-3333) of the occurrence at the Optometry building.

Someone should be appointed to meet emergency personnel curbside and direct them immediately to the appropriate area of the building.

The minor surgery room is equipped to handle emergencies of all types. A complete resuscitation kit, oxygen, EKG monitor, surgical gurney, etc., are all available. This equipment may be carefully moved to another area in the clinic if the patient cannot be safely transported to the minor surgery room.

All emergency cases should be documented by filing an incident report to the Executive Director of the UEI.
Management of Acute Angle Closure Glaucoma

Acute angle closure glaucoma should be regarded as a medical emergency. Therapy should be directed at rapidly reducing the intraocular pressure and in opening the angle. Both medical and laser treatment play a role in opening the angle and in eliminating pupillary block.

Dilation in eyes with shallow anterior chambers and narrow angles is a calculated risk. Before instilling mydriatic drops, the patient's medical history should be critically reviewed. Special note should be made of any underlying systemic diseases that would contraindicate the use of oral and/or topical medications employed to break the attack. The patient's habitual medications must be researched to exclude potential drug interactions. The patient’s cardiovascular, volume, and pulmonary status must be evaluated and their electrolyte balance and renal function considered before dilation.

High risk patients should be dilated early in the day as angle closure is most likely to occur as the pupil slowly returns from the maximally dilated position. A rise in intraocular pressure typically occurs in one to three hours after installation of mydriatic drops. Forewarn the patient of the possibility of angle closure, dilate one eye only, and observe the patient until the pupil has returned to its near normal state. Adrenergic agents, especially 10% phenylephrine, carry a greater risk than mydriatics that paralyze the sphincter. Tropicamide is weakly cycloplegic, of short duration, and can usually be reversed with low concentration of pilocarpine. Thus tropicamide (preferably 0.5%) should be the drug selected in dilating this at risk patient population.

Symptoms of Angle Closure

In a complete angle closure, the eye is red and painful. The patient will often complain of hazy vision and see colored haloes around lights. The cornea will appear cloudy due to edema and the pupil will typically be mid-dilated and fixed. Some patients will experience significant nausea and abdominal distress due to autonomic stimulation.

Signs of Angle Closure

The critical signs of an angle closure attack are an occluded angle in the involved eye, acutely elevated intraocular pressure and corneal microcystic edema. A rise of 2-4 mm Hg from the intraocular pressures taken before dilation is highly suspicious of early angle closure. Gonioscopic confirmation of angle closure is essential, since cycloplegics can cause an intraocular pressure rise in eyes with open angles, even in the absence of pigment liberation.

When Angles Close

There is no absolute "cookbook" method for managing every angle closure attack. Each case should be evaluated and handled on an individual basis. Listed below are guidelines for an angle closure attack.

1 Examine the affected eye and the fellow eye.

2 Gonioscope both anterior chamber angles (gonioscopy of an edematous cornea may predispose to a corneal abrasion). Gonioscopy of the involved eye after the IOP is lowered is essential in determining whether the angle has indeed opened.
3 Instill 1 drop of a topical beta-blocker (levobunolol 0.5% or timolol 0.5% x 1) and 1 drop of topical alpha-adrenergic agonist (e.g. apronidine 0.5%). Beta-blockers may cause bradycardia, hypotension, and/or exacerbate congestive heart failure. They are also known to produce increased airway resistance and may be contraindicated in severe diabetics.

4 Administer an oral carbonic anhydrase inhibitor. Acetazolamide (250-500mg p.o.) is highly effective and can open some closed angles even in the presence of ischemic iris atrophy and paralysis of the pupil. Because acetazolamide is a sulfonamide, there is a chance of sensitivity with sulfa allergies. CAI's can produce a metabolic acidosis and may also induce a sickle cell crisis in patients with sickle cell anemia.

5 After these measures, reassess the ocular findings in one hour. The intraocular pressure is usually decreased but the angle may remain appositionally closed. One drop of 1%-2% pilocarpine is given and the patient re-examined 30 minutes later.

   a. If the intraocular pressure is reduced and the angle is open, the patient may be treated medically with topical low dose pilocarpine (1%-2%), beta-blockers, topical steroids, and oral acetazolamide if necessary until the eye is quiet and laser iridectomy can be performed.

   b. If the intraocular pressure is unchanged or elevated and the angle remains closed, lens related angle closure should be suspected, further pilocarpine withheld, and the attack broken by laser therapy.

Other Treatment

Physical methods have been reported to be successful in treating acute angle closure. Indentation of the central cornea with a Zeiss four mirror lens, cotton tip applicator, or muscle hook will force aqueous humor peripherally and may open the angle temporarily. This procedure may be quite uncomfortable for the patient.

Angle-closure glaucoma is associated with a marked inflammatory reaction. The instillation of 1% prednisolone or 0.1% dexamethesone is desirable to reduce inflammation before laser surgery. Severe pain may be treated with analgesics and vomiting may be controlled with anti-emetics. If vomiting is severe, hyperosmotic agents and carbonic anhydrase inhibitors must be given intravenously.

Follow Up

If the IOP drops significantly and the angle is determined to be opened by gonioscopy, definitive iridectomy is performed once the cornea is clear and the anterior chamber is quiet.
Guidelines for Use of Ophthalmic Drug Samples

- **Glaucoma**
  - Sample and dispense one bottle initially to evaluate the drug’s effect of intraocular pressure.
  - Write and issue a prescription after a successful follow up visit.
  - Write and issue a refill prescription on future follow up visits – **do not provide additional samples**.

- **Allergy**
  - Sample and dispense one bottle and a written prescription for new medications
  - Supply written refill prescriptions on subsequent visits
  - Do not sample returning allergy patients unless it is a new medication.

- **Anti-Infectives**
  - Sample one drop while the patient is in the chair to initiate therapy.
  - Write and issue the prescription.
  - Advise the patient to fill the script immediately.
  - Only provide a sample in extreme situations in which a patient cannot get to a pharmacy on the same day to fill the prescription.
  - Never provide a sample without a prescription.

- **Dry Eye OTC**
  - Sample and dispense one bottle of product during the eye examination and consider providing a written prescription for the product to enhance compliance.

- **Contact Lens Solutions**
  - Sample only one starter kit per patient each year and provide your written recommendation for the product your patient should purchase to increase compliance.
  - Do not give the patient multiple sample bottles.
  - Do not give the patient different sample starter kits or rewetting drops on the same visit.

- **New Pharmaceutical Products**
  - When an OTC or prescription pharmaceutical product is introduced, a sample might be used by a practitioner or achieve a level of clinical comfort with the product.
  - Dispensing of a sample should still generally be accompanied by a written prescription for the pharmaceutical, in the case of both OTC and prescription products.

Use your discretion in sampling in situations when it may be difficult for a patient to get to the pharmacy in a timely manner (weekends, late evening). To aid in compliance, consider calling in the prescription to the pharmacy on behalf of the patient.
PATIENT BILL OF RIGHTS

In an institutional setting, it is easy to forget that the patient is an individual with personal needs and expectations. There is often a tendency to consider the patient as a subject or just another of a large number of persons processed through the clinic. Proper health care requires the development of a close doctor-patient relationship based on mutual respect and understanding. In order to reinforce this premise, the University Eye Institute has adopted the following Patient's Bill of Rights. Adherence to these concepts will help to ensure that we are providing competent and considerate care to all of our patients.

1. The patient has the right to the most appropriate optometric, ophthalmological and/or other health care for a particular problem, regardless of race, color, sex, age, religion, national origin, mental/physical handicap or ability to pay.

2. The patient has the right to expect that individuality will be respected and differences in educational and cultural background will be considered in his/her case.

3. The patient has the right to be treated with dignity and respect, to be addressed by his/her proper name and without undue familiarity, to be listened to and to receive an appropriate response.

4. The patient has the right to be treated in a warm, friendly and unhurried manner in an atmosphere of concern and frankness. The patient has the right to comfortable, clean and appealing surroundings while at the University Eye Institute.

5. The patient has the right to know the name of all providers and observers; the student clinician, intern, optometrist or physician rendering patient care.

6. The patient has the right to a full explanation regarding the diagnosis, treatment, prognosis, and treatment alternatives.

7. The patient has the right to information on financial assistance when they are unable to afford appropriate care.

8. The patient has the right to accurate and complete information regarding the extent, cost, and nature of services available to them.

9. The patient has the right to be advised if the University Eye Institute proposes to engage in or perform clinical trials as a component of their care or treatment. The patient has the right to refuse to participate in such research projects and to receive more traditional care.

10. The patient has the right to know when they are participating in research investigations and to give prior, full, valid and informed consent.

11. The patient has the right to privacy and the right to talk with all University Eye Institute personnel without being overheard.
12. The patient has the right to confidentiality of his/her records which will not be released to third parties without signed consent. Records will be made available to the patient upon written request.

13. The patient has the right to know the risks, benefits and obligations associated with the services provided to them.

14. The patient has the right to appropriate referral when indicated.

15. The patient has the right to seek another opinion if desired.

16. The patient has the right to refuse treatment.

17. The patient has the right to the continuity of his/her care.

18. The patient has the right to prompt attention in an emergency situation.

19. When a treatment plan includes optical corrections, the patient will be given the choice of having it filled at the University Eye Institute or elsewhere. The patient has the right to receive a copy of his/her spectacle prescription.

20. The patient has the right to receive an explanation of fees and charges regardless of the source of payment.

Patients should also understand their responsibility to:

1. Respect the rights of other patients and University Eye Institute personnel.
2. Give accurate and complete health information.
3. Make every attempt to carry out the specific plan of care.
4. Accept responsibility for outcomes if instructions are not followed.
5. Promptly meet financial obligations.

No catalog of rights can guarantee for the patient the kind of treatment he/she may justly expect. The University Eye Institute has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All of these activities must be delivered with an overarching concern for the patient, and above all, the recognition of his/her dignity as a human.
Grievance Policy for the University Eye Institute

POLICY

It is the policy of the University Eye Institute (UEI) to ensure that all complaints related to care or services provided, are dealt with as courteously, consistently, and as expeditiously as possible. If the initial efforts of the Service Director or Department Manager fail to amicably settle complaints, it is the policy of the UEI to utilize this grievance procedure to make reasonable efforts to resolve patient related issues as quickly as possible.

A Patient Complaint is a verbal or written criticism regarding patient care received, which is addressed at the time of the visit by an attending or by a staff member. A complaint is considered resolved when the patient, or the patient’s representative, is satisfied with the actions taken.

A Patient Grievance is a verbal or written complaint by a patient, or patient representative, regarding patient care that is voiced or received after the visit. This concern is submitted to, or received by, a representative of the UEI and requires further action or resolution.

PURPOSE

The purpose of this policy is to provide a system whereby patients, or their representatives, may express concerns and recommend changes freely, without being subject to coercion, discrimination, or unreasonable interruption of care.

PROCEDURE

Notice of Right to File Grievance

A sign is posted in a prominent position in the UEI that notifies patients and their representatives of the UEI’s goal to provide the highest quality patient care possible. Should there be a concern that the patient feels has not been resolved, the patient may request a grievance form from the receptionist or contact the Coordinator of Clinics.

INITIAL RESPONSE TO THE COMPLAINANT

Nonsupervisory personnel who receive a Patient Complaint from a patient, or a patient’s family member or representative, either written, by phone, or in person, will refer the complaint to the Associate Director of the UEI.

The Associate Director of the UEI will attempt to gather all salient facts of the encounter. The Associate Director will determine a mutually agreed-upon time to reconvene, either in person or by phone, to report the investigation’s findings. This investigational time should not exceed seven (7) working days. All actions and conversations should be documented on the Complainant form.
NOTIFICATION OF INVESTIGATION RESULTS

Upon completion of the investigative process, the Executive Director of the UEI or the Dean of the College, will contact the complainant with the results of the investigation. The notification should be in the form of disclosure of actions taken, findings, actions recommended, and any changes made in the practice processes. In instances where the complaint is against a specific employee, the results of actions taken will remain confidential. The complainant will learn only that appropriate steps were taken to remedy the complaint.

RESOLUTION

A patient’s grievance is considered resolved when the patient, or patient’s representative, is satisfied with the action taken.

There may be times where the UEI has made appropriate and reasonable endeavors to resolve the grievance and the patient or patient’s representative remains dissatisfied. In these cases, the UEI will close the file for purposes of this policy.

In some cases, additional action might need to be initiated, such as notifying the University General Council or discharging the patient from the practice.
MANAGING PATIENT DELAYS

Regardless of the reason for the delay, recognize it, apologize to the patient and explain the situation. Example: “I am sorry that we are behind schedule. We have had some emergencies which caused us to run late” (only say this if it is true). Assure them that they will receive the same attention, consideration, and careful examination as the patients seen before them. Most people will understand and appreciate the apology and explanation which can easily defuse an angry patient. After consoling the patient, make every effort to get them into the exam room as soon as possible.
FEES

General Information

A paper fee bill will be issued to each patient on every clinical visit. Payment is expected on the day services are rendered.

Services, procedures and/or materials should be identified and coded appropriately within the patient’s Electronic Medical Record (EMR). Completed records must be approved by the faculty and verified by the Service Coordinator. Patients should then be escorted by the student clinician to the cashier for payment. Students should never cut in line or go straight to a cashier if there are people waiting in line. OD/Med patients must have a routing slip accompany them to the cashier to properly identify the patient’s record. For those patients having no fee payment, the charges must still be coded in the patient’s EMR along with the reason charges are being waived. All fee waivers other than prescription re-checks or contact lens adaptations must be approved by the Clinic Service Director or the Executive Director of the UEI.

Credit

It is not the policy of the University Eye Institute to issue or arrange credit to patients. Indigent patients should be interviewed by the designated Clinic Business Office staff prior to the patient’s appointment. The Clinic Service Director may make individual arrangements with patients as the need arises.

Charging of Fees

It is the responsibility of the student clinician, staff, attending faculty, opticians and Service Directors to see that UEI professional fees are properly assessed when services or materials are provided. Fee adjustments can be made by authorized individuals only.

PROTOCOLS for USE of the FEE BILL

Reception Area

As patients arrive they should be given the fee bill and requested to sign a Financial Policy/Assignment of Benefits form that includes the patient's name, date, any insurance or other special program information, and Service. The patient is then sent to the appropriate Service where he/she may be given an intake questionnaire to complete. Upon completion, the questionnaire is placed with the patient's fee bill.

Walk-In Patients

A fee bill should be obtained from the reception desk by all walk-in patients.

Patient Care Services

When the fee bill is received by the Service Coordinator, the resident should ensure that the faculty name is listed if not yet licensed or the resident is not credentialed for the insurance plan. The patient number must also be listed. After the examination, any Rx should been entered in the OME ExamWriter. In addition, the resident must enter all codes and procedures. The following check list may be of value.
♦ All professional services and materials must be entered.

♦ All diagnostic codes must be entered.

♦ The resident provider number, (and faculty's if needed) must be entered. The resident (and faculty, if needed) must sign the form.

Prior to licensure or for patients on insurance plans the resident is not credentialed on, residents must have faculty sign fee slips prior to the patient leaving the clinic. The resident should open the EMR for this patient with themselves listed as the attending. When the chart is complete the attending should be changed to the faculty who signed the fee slip. This indicates to the faculty the chart is ready for their review and signature. In addition, the resident must include themselves as the assistant attending on the EMR, leaving the attending slot for the faculty to electronically sign.

**Material Fees**

Optical and/or contact lens materials must be entered into OfficeMate in the appropriate area. Contact lens charges post to fee bill when the resident creates a lab order in the EMR. A written order form must also be submitted to the Cornea & Contact Lens staff. All charges are verified in OfficeMate by clinic staff prior to escorting the patient to the cashier.

**Medicare/Medicaid**

If the patient simply wanted an eye examination or new glasses and a pathology is discovered, Medicare **will not pay**. **Medicare will pay for medically necessary visits only.** If an eligible patient expresses that the reason for the eye exam was eye pain, sudden blurred vision, to see if they had cataracts, was a diabetic patient, etc., (pathology symptoms) then all diagnostic procedures, except refraction, are covered by Medicare.

The Clinic Business Office will process all Medicare/Medicaid claims according to the information entered into OfficeMate. **To protect yourself and the College from liability, be sure all charges have been entered correctly into OfficeMate/ExamWriter.**
Determine the extent of HISTORY obtained:
The levels of E/M services recognize four types of history that are defined as follows:
- **Problem Focused** -- chief complaint; brief history of present illness or problem.
- **Expanded Problem Focused** -- chief complaint; brief history of present illness; problem pertinent system review.
- **Detailed** -- chief complaint; extended history of present illness; extended system review; pertinent past, family and/or social history.
- **Comprehensive** -- chief complaint; extended history of present illness; complete system review; complete past, family, and social history.

Determine the extent of EXAMINATION performed:
The levels of E/M services recognize four types of examination that are defined as follows:
- **Problem Focused** -- an examination that is limited to the affected body area or organ system.
- **Expanded Problem Focused** -- an examination of the affected body area or organ system and other symptomatic or related organ systems.
- **Detailed** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- **Comprehensive** -- a complete single system specialty examination or a complete multi-system examination.

Determine the Nature of the Presenting Problem:
A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. There are five levels of presenting problems:
- **Minimal** - a problem that may not require the presence of a physician, but service is provided under the physician's supervision.
- **Self-Limited or Minor** - the problem runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status or has a good prognosis with management and compliance.
- **Low Severity** - risk of morbidity without treatment is low; little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- **Moderate Severity** - risk of morbidity and mortality without treatment is moderate; uncertain prognosis or increased probability of prolonged functional impairment.
- **High Severity** - risk of morbidity without treatment is high to extreme; moderate to high risk of mortality without treatment or high probability of severe prolonged functional impairment.

Also, remember that special ophthalmological services such as refraction (92015) and procedure codes 92020 through 92499 are now billed bilaterally. If only one eye is performed, a 52 modifier must be inserted after the code and the patient billed only 60% of the regular fee.

Determine the complexity of MEDICAL DECISION MAKING:
Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, two of the three elements in the following table must be met or exceeded.

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications and/or morbidity or mortality</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
LEVELS OF SERVICE

New Patient

A new patient is one who has not received any medical services from the physician within the past three years. Each code requires that the specified level of all three of the key components history, exam, and decision-making must be met. Remember that the time expended is only a guideline unless counseling and/or coordination of care dominates more than 50% of the face-to-face time, then it becomes the controlling factor for selection of E/M services.

99201 - requires a problem-focused history and examination and straightforward medical decision-making. Usually the presenting problems are self-limited or minor. Doctors spend about 10 minutes face-to-face with the patient and/or family.

99202 - requires an expanded problem focused history and exam and straightforward medical decision-making. Usually the presenting problems are of low to moderate severity. Doctors typically spend 20 minutes face-to-face with the patient and/or family.

99203 - requires a detailed history and exam, and medical decision-making of low complexity. Usually the presenting problems are of moderate severity. Doctors typically spend 30 minutes face-to-face with the patient and/or family.

99204 - requires a comprehensive history and exam and medical decision-making of moderate complexity. Usually the presenting problems are of moderate to high severity. Doctors typically spend 45 minutes face-to-face with the patient and/or family.

99205 - requires a comprehensive history and exam and medical decision-making of high complexity. Usually the presenting problems are of moderate to high severity. Doctors typically spend 60 minutes face-to-face with a patient and/or family.

Established Patient

A patient who has received medical services from the doctor within the past three years. A major difference for an established patient is that they require at least two of the three key components of history, exam, and decision-making.

99211 - Office or other outpatient visit for the evaluation and management of an established patient. The visit may not require doctor's presence. Usually the presenting problems are minimal and the services typically take about 5 minutes.

99212 - requires at least two of these three key components: problem-focused history, problem-focused exam, and straightforward medical decision-making. Usually the presenting problems are self-limited or minor. Doctors typically spend 10 minutes face-to-face with a patient and/or family.

99213 - requires at least two of these three key components: expanded problem-focused history, expanded problem-focused exam, and decision-making of low complexity. Usually the presenting problems are of low to moderate severity. Doctors typically spend 15 minutes face-to-face with the patient and/or family.

99214 - requires at least two of the three components: detailed history, detailed exam, and decision-making of moderate complexity. Usually the presenting problems are of moderate to high severity. Doctors typically spend 25 minutes face-to-face with a patient and/or family.

99215 - requires at least two of the three components: comprehensive history, comprehensive exam, and medical decision-making of high complexity. Usually the presenting problems are of moderate to high severity. Doctors typically spend 40 minutes face-to-face with a patient and/or family.
FEE ADJUSTMENTS

ECAP Program

The University Eye Institute is committed to provide optimal vision services whenever possible regardless of the ability to pay. Patients who cannot afford the fee for examination services or spectacles should be referred to the Clinic Business Office before the exam for information on our ECAP program.

Patients are screened for a fee adjustment on the basis of income and family dependents. The scale used is the Poverty Income Guidelines as set by the Department of Health and Human Services and is similar to the scale employed by the Harris County Hospital District.

Patients are asked to provide information on income and verification is required. Patients may speak to the designated staff in the Clinic Business Office prior to an appointment. The patient will be advised regarding the specific information requested for fee adjustments. Unless specifically noted, ECAP qualifies the patient for reduced fees for one year, after which the patient will need to requalify. Patients can be referred to the Clinic Business Office for a fee adjustment screening prior to the day of their appointment. Designated employees in the Clinic Business Office have the authority to verify the patient’s income and complete the fee adjustment forms. If there are specific questions that need to be addressed you may request to speak to the UEI Clinic Business Office Manager.

There are established prescription guidelines for spectacle lenses available through the ECAP program. For powers outside these limits, all efforts will be made to provide lenses at a reduced cost. Should the patient choose to add extras that cost will be paid by the patient.

Patients who are prescribed contact lenses because their vision cannot be corrected with a spectacle Rx and they cannot afford contact lenses, should be referred to the Director of the Cornea and Contact Lens Service before the lenses are fitted. Individual arrangements may be made for reduction of professional service fees. However, payment must be received for all materials at the usual and customary rate unless otherwise approved.

Educational Purposes

Service Directors may make individual arrangements with a patient who qualifies for a reduction in fees for educational purposes. Only the Executive Director of the UEI and/or Service Directors have the authority to approve the educational fee adjustments.

Other Resources

The following resources are available for patients who cannot afford payment for the spectacle Rx or contact lenses. For example:

1. New Eyes for the Needy: We receive a limited number of vouchers per month from this organization to pay for glasses and frames.

Details are available in the UEI Clinic Business office.
No Charge - No Payment Due

All patients seen without incurring additional charges should be managed in the same manner as paying patients when they exit the clinic. The patient must be escorted to the service office to have the staff review the fee bill. Then patient is then escorted to the reception area and thanked for utilizing the University Eye Institute for their vision care. The cashier should promptly review for accuracy then process according to the Clinic Business Office policy.

Gratis/Professional Courtesy

Professional courtesy may only be approved through the Executive Director of the UEI or Service Directors. This may be in the form of total or partial fee waiving. The University Eye Institute extends professional courtesy to its faculty, staff, students, and members of their immediate family, if third party payment is not available or does not apply.

Immediate family is defined as spouse, children, parents, and siblings. Professional courtesy will be extended for services only. In no instance will material costs be waived.

Research Subjects

Occasionally, research subjects will be compensated for participation in approved projects. Investigators must acquire and fill out proper fee waiver forms and present them to the appointment clerk or Service Coordinator when making the subject's appointment.

Sponsored Program Fees

Occasionally, organizations will sponsor screenings and/or vision examinations for specific patient groups. Fee arrangements will be made in advance and will not follow normal billing procedures.
PROFESSIONAL COURTESY FOR SERVICES AND MATERIALS

Courtesy fee reductions are provided to UHCO/UH Faculty, Staff, Current Students, UHCO Retirees and their Spouses and UH Retirees by the University Eye Institute. In all cases, if the patient has insurance, it will be billed but the patient may be eligible for a fee waiver or a refund to cover the expense. In all cases, the patient will be responsible for any deductibles that might apply.

Details are available in the UEI Student Policies Manual on the intranet at http://intranet.opt.uh.edu/student/UEI-Student-Policies.pdf

Residents may purchase eyeglasses for personal use at invoice cost plus a dispensing fee.
EQUIPMENT ROOM PROTOCOLS

Equipment checked out to a resident for clinic use remains the responsibility of the resident until it is returned and inspected by both the resident and equipment room clerk.

Equipment that leaves the equipment room should be inspected by the person who is checking the equipment out to make sure that it is intact. If equipment is not intact, it should be brought to the equipment room clerk's attention at the time of check-out.

Residents will be charged the full cost for replacement of lost equipment.

Equipment Maintenance and Repair

When equipment malfunctions, an equipment repair form, located on the EMR computer desktop should be completed and emailed. The Instrument Service Department will schedule the repair as soon as possible.

Replacement bulbs for all clinic instrumentation are located in the Equipment Room 1219. If a bulb is not available in this room, contact personnel in Room 1000.

Any problem with the building should be called to the attention of the Service Coordinator. Physical plant personnel can then be notified to arrange repair.

In the event the Instrument Service Department is not available and the problem is an emergency, contact the office of the Assistant Dean.
## COMMON ABBREVIATIONS

### History, Evaluation and Management

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AMA</td>
<td>against medical advise</td>
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<tr>
<td>Hx</td>
<td>history</td>
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<tr>
<td>OHx</td>
<td>ocular history</td>
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<tr>
<td>FHx</td>
<td>family history</td>
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<tr>
<td>c/o</td>
<td>complains of</td>
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<tr>
<td>f/u</td>
<td>follow-up</td>
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<tr>
<td>cc, cvc</td>
<td>chief visual complaint</td>
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<td>LPE</td>
<td>last physical examination</td>
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<td>HA</td>
<td>headaches</td>
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<td>Dx</td>
<td>diagnosis</td>
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<td>Fx</td>
<td>findings</td>
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<td>Mx</td>
<td>management</td>
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<tr>
<td>Px</td>
<td>prognosis</td>
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<tr>
<td>Sx</td>
<td>symptoms</td>
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<tr>
<td>Tx</td>
<td>treatment</td>
</tr>
<tr>
<td>Rx</td>
<td>prescription</td>
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<tr>
<td>c, cc</td>
<td>with</td>
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<tr>
<td>s, sc</td>
<td>without</td>
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<tr>
<td>+</td>
<td>positive or present</td>
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<tr>
<td>-</td>
<td>negative or absent</td>
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<tr>
<td>WNL</td>
<td>within normal limits</td>
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<tr>
<td>r/o</td>
<td>rule out</td>
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<tr>
<td>WD</td>
<td>working distance</td>
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<td>LV</td>
<td>low vision</td>
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<tr>
<td>LVA</td>
<td>low vision aid</td>
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<tr>
<td>RTC</td>
<td>return to clinic</td>
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<tr>
<td>CV</td>
<td>color vision</td>
</tr>
<tr>
<td>BP</td>
<td>blood pressure</td>
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<tr>
<td>S</td>
<td>subjective</td>
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<tr>
<td>O</td>
<td>objective</td>
</tr>
<tr>
<td>A</td>
<td>assessment</td>
</tr>
<tr>
<td>P</td>
<td>plan</td>
</tr>
<tr>
<td>IMP</td>
<td>impression</td>
</tr>
<tr>
<td>IOP</td>
<td>intraocular pressure</td>
</tr>
<tr>
<td>T</td>
<td>tonometry</td>
</tr>
<tr>
<td>TAP</td>
<td>tension by applanation (Goldmann)</td>
</tr>
<tr>
<td>NCT</td>
<td>noncontact tonometry</td>
</tr>
<tr>
<td>SLE</td>
<td>slit-lamp examination</td>
</tr>
<tr>
<td>DFE</td>
<td>dilated fundus examination</td>
</tr>
<tr>
<td>MIO</td>
<td>monocular indirect ophthalmoscopy</td>
</tr>
<tr>
<td>BIO</td>
<td>binocular indirect ophthalmoscopy</td>
</tr>
<tr>
<td>DO</td>
<td>direct ophthalmoscopy</td>
</tr>
<tr>
<td>VF</td>
<td>visual fields</td>
</tr>
<tr>
<td>ERG</td>
<td>electrotinogram</td>
</tr>
<tr>
<td>EOG</td>
<td>electro-oculogram</td>
</tr>
<tr>
<td>VEP</td>
<td>visually evoked potential</td>
</tr>
<tr>
<td>ODM</td>
<td>ophthalmodynamometry</td>
</tr>
<tr>
<td>OKN</td>
<td>optokinetic nystagmus</td>
</tr>
<tr>
<td>PST</td>
<td>photostress test</td>
</tr>
<tr>
<td>W4D</td>
<td>Worth 4 Dot</td>
</tr>
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</table>

### Acuity

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA</td>
<td>visual acuity</td>
</tr>
<tr>
<td>PH</td>
<td>pinhole</td>
</tr>
<tr>
<td>NLP</td>
<td>no light perception</td>
</tr>
<tr>
<td>CF</td>
<td>counting fingers</td>
</tr>
<tr>
<td>HM</td>
<td>hand motion</td>
</tr>
<tr>
<td>LP</td>
<td>light perception</td>
</tr>
<tr>
<td>LPR, LP'</td>
<td>light projection</td>
</tr>
<tr>
<td>ND</td>
<td>neutral density</td>
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### Refraction

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>W, Hab</td>
<td>current (habitual) spectacle prescription</td>
</tr>
<tr>
<td>R</td>
<td>retinoscopy</td>
</tr>
<tr>
<td>M</td>
<td>manifest refraction</td>
</tr>
<tr>
<td>BVA</td>
<td>best visual refraction</td>
</tr>
<tr>
<td>PH</td>
<td>pin hole</td>
</tr>
<tr>
<td>PHNI</td>
<td>pin hole - no improvement</td>
</tr>
<tr>
<td>SM</td>
<td>simple myopia</td>
</tr>
<tr>
<td>SMA</td>
<td>simple myopic astigmatism</td>
</tr>
<tr>
<td>CMA</td>
<td>compound myopic astigmatism</td>
</tr>
<tr>
<td>SH</td>
<td>simple hyperopia</td>
</tr>
<tr>
<td>SHA</td>
<td>simple hyperopic astigmatism</td>
</tr>
<tr>
<td>CHA</td>
<td>compound hyperopic astigmatism</td>
</tr>
<tr>
<td>MA</td>
<td>mixed astigmatism</td>
</tr>
<tr>
<td>WRA</td>
<td>with-the-rule astigmatism</td>
</tr>
<tr>
<td>ARA</td>
<td>against-the-rule astigmatism</td>
</tr>
<tr>
<td>D</td>
<td>diopter</td>
</tr>
<tr>
<td>DS</td>
<td>diopter sphere</td>
</tr>
<tr>
<td>X, CX</td>
<td>axis of cylinder</td>
</tr>
<tr>
<td>K</td>
<td>keratometry</td>
</tr>
<tr>
<td>JCC</td>
<td>Jackson cross cylinder</td>
</tr>
<tr>
<td>FCC</td>
<td>fused cross cylinder (14B)</td>
</tr>
<tr>
<td>R-G</td>
<td>red-green</td>
</tr>
<tr>
<td>PL</td>
<td>plano</td>
</tr>
<tr>
<td>LIP</td>
<td>lens in phoropter</td>
</tr>
<tr>
<td>N</td>
<td>near</td>
</tr>
<tr>
<td>ACC</td>
<td>accommodation</td>
</tr>
<tr>
<td>AMP</td>
<td>amplitude of accommodation</td>
</tr>
<tr>
<td>PRA</td>
<td>positive relative accommodation</td>
</tr>
<tr>
<td>NRA</td>
<td>negative relative accommodation</td>
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</tbody>
</table>
### Binocular Vision

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>vertical orthophoria</td>
</tr>
<tr>
<td>CT</td>
<td>cover test</td>
</tr>
<tr>
<td>EP</td>
<td>esophoria at distance</td>
</tr>
<tr>
<td>EP'</td>
<td>esophoria at near</td>
</tr>
<tr>
<td>ET</td>
<td>esotropia at distance</td>
</tr>
<tr>
<td>ET'</td>
<td>esotropia at near</td>
</tr>
<tr>
<td>E(T)</td>
<td>intermittent esotropia at distance</td>
</tr>
<tr>
<td>E(T')</td>
<td>intermittent esotropia at near</td>
</tr>
<tr>
<td>XP</td>
<td>exophoria at distance</td>
</tr>
<tr>
<td>XP'</td>
<td>exophoria at near</td>
</tr>
<tr>
<td>XT</td>
<td>exotropia at distance</td>
</tr>
<tr>
<td>XT'</td>
<td>exotropia at near</td>
</tr>
<tr>
<td>X(T)</td>
<td>intermittent exotropia at distance</td>
</tr>
<tr>
<td>X(T')</td>
<td>intermittent exotropia at near</td>
</tr>
<tr>
<td>HT</td>
<td>hypertropia</td>
</tr>
<tr>
<td>NPC</td>
<td>near point of convergence</td>
</tr>
<tr>
<td>PD, IPD</td>
<td>interpupillary distance</td>
</tr>
<tr>
<td>AC/A</td>
<td>accommodative convergence/accommodation ratio</td>
</tr>
<tr>
<td>VT</td>
<td>vision training or therapy</td>
</tr>
<tr>
<td>FD</td>
<td>fixation disparity</td>
</tr>
<tr>
<td>EF</td>
<td>eccentric fixation</td>
</tr>
<tr>
<td>NRC</td>
<td>normal retinal correspondence</td>
</tr>
<tr>
<td>ARC</td>
<td>anomalous retinal correspondence</td>
</tr>
<tr>
<td>AMBL</td>
<td>amblyopia</td>
</tr>
<tr>
<td>CON</td>
<td>constant</td>
</tr>
<tr>
<td>COM</td>
<td>comitant</td>
</tr>
<tr>
<td>NON-COM</td>
<td>non-comitant</td>
</tr>
</tbody>
</table>

### Contact Lenses

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCL</td>
<td>hard contact lens</td>
</tr>
<tr>
<td>SCL</td>
<td>soft contact lens</td>
</tr>
<tr>
<td>GPH</td>
<td>gas permeable hard</td>
</tr>
<tr>
<td>DW</td>
<td>daily wear</td>
</tr>
<tr>
<td>EW</td>
<td>extended wear</td>
</tr>
<tr>
<td>OAD</td>
<td>over all diameter</td>
</tr>
<tr>
<td>OZD</td>
<td>optical zone diameter</td>
</tr>
<tr>
<td>BC</td>
<td>base curve radius</td>
</tr>
<tr>
<td>SC</td>
<td>secondary curve radius</td>
</tr>
<tr>
<td>PC/W</td>
<td>peripheral curve radius/width</td>
</tr>
<tr>
<td>K's</td>
<td>keratometry readings</td>
</tr>
<tr>
<td>HVID</td>
<td>horizontal visible iris diameter</td>
</tr>
<tr>
<td>FLP</td>
<td>fluorescein pattern</td>
</tr>
<tr>
<td>MVMT</td>
<td>movement</td>
</tr>
<tr>
<td>WT</td>
<td>wearing time</td>
</tr>
<tr>
<td>MWT</td>
<td>maximum wearing time</td>
</tr>
<tr>
<td>RA</td>
<td>residual astigmatism</td>
</tr>
<tr>
<td>TBUT</td>
<td>tear break-up time</td>
</tr>
<tr>
<td>OR</td>
<td>over-refraction</td>
</tr>
<tr>
<td>SA</td>
<td>service agreement</td>
</tr>
<tr>
<td>NC</td>
<td>no charge</td>
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### Pathology

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Definition</th>
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<tbody>
<tr>
<td>MERD</td>
<td>meridional</td>
</tr>
<tr>
<td>DB</td>
<td>diabetes</td>
</tr>
<tr>
<td>HTN</td>
<td>hypertension (systemic)</td>
</tr>
<tr>
<td>CVD</td>
<td>cardiovascular disorder</td>
</tr>
<tr>
<td>DR</td>
<td>background diabetic retinopathy</td>
</tr>
<tr>
<td>PPDR</td>
<td>preproliferative diabetic retinopathy</td>
</tr>
<tr>
<td>PDR</td>
<td>proliferative diabetic retinopathy</td>
</tr>
<tr>
<td>NVM</td>
<td>neovascular membrane</td>
</tr>
<tr>
<td>PRP</td>
<td>panretinal photocoagulation</td>
</tr>
<tr>
<td>GTT</td>
<td>glucose tolerance test</td>
</tr>
<tr>
<td>HTN</td>
<td>hypertension</td>
</tr>
<tr>
<td>HR</td>
<td>hypertensive retinopathy</td>
</tr>
<tr>
<td>RD</td>
<td>retinal detachment</td>
</tr>
<tr>
<td>WWOP</td>
<td>white without pressure</td>
</tr>
<tr>
<td>WWP</td>
<td>white with pressure</td>
</tr>
<tr>
<td>ARMD</td>
<td>age related macular degeneration</td>
</tr>
<tr>
<td>CNVM</td>
<td>choroidal neovascular membrane</td>
</tr>
<tr>
<td>CSR</td>
<td>central serous retinopathy</td>
</tr>
<tr>
<td>CME</td>
<td>cystoid macular edema</td>
</tr>
<tr>
<td>ROP</td>
<td>retinopathy of prematurity</td>
</tr>
<tr>
<td>AS</td>
<td>arteriolar sclerosis</td>
</tr>
<tr>
<td>CRAO</td>
<td>central retinal artery occlusion</td>
</tr>
<tr>
<td>CRVO</td>
<td>central retinal vein occlusion</td>
</tr>
<tr>
<td>TIA</td>
<td>transient ischemic attack</td>
</tr>
<tr>
<td>CVA</td>
<td>cerebral vascular accident</td>
</tr>
<tr>
<td>IRMA</td>
<td>intraretinal microangiopathy</td>
</tr>
<tr>
<td>CSME</td>
<td>clinically significant macular edema</td>
</tr>
<tr>
<td>NVD</td>
<td>neovascularization of the disc</td>
</tr>
<tr>
<td>NVE</td>
<td>neovascularization elsewhere</td>
</tr>
<tr>
<td>SRNM</td>
<td>subretinal neovascular membrane</td>
</tr>
<tr>
<td>HEM</td>
<td>hemorrhage</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>TA</td>
<td>temporal arteritis</td>
</tr>
<tr>
<td>GLC</td>
<td>glaucoma</td>
</tr>
<tr>
<td>COAG</td>
<td>chronic open angle glaucoma</td>
</tr>
<tr>
<td>CAG</td>
<td>closed angle glaucoma</td>
</tr>
<tr>
<td>OHT</td>
<td>ocular hypertension</td>
</tr>
<tr>
<td>LPI</td>
<td>laser peripheral iridotomy</td>
</tr>
<tr>
<td>LTP</td>
<td>laser trabeculoplasty</td>
</tr>
<tr>
<td>PAS</td>
<td>peripheral anterior synechiae</td>
</tr>
<tr>
<td>PS</td>
<td>posterior synechiae</td>
</tr>
<tr>
<td>CAT</td>
<td>cataract</td>
</tr>
<tr>
<td>PSC</td>
<td>posterior subcapsular cataract</td>
</tr>
<tr>
<td>ASC</td>
<td>anterior subcapsular cataract</td>
</tr>
<tr>
<td>NS</td>
<td>nuclear sclerosis</td>
</tr>
<tr>
<td>IOL</td>
<td>intraocular lens</td>
</tr>
<tr>
<td>ICCE</td>
<td>intracapsular cataract extraction</td>
</tr>
<tr>
<td>ECCE</td>
<td>extracapsular cataract extraction</td>
</tr>
<tr>
<td>KP</td>
<td>keratic precipitates</td>
</tr>
<tr>
<td>KCS</td>
<td>keratoconjunctivitis sicca</td>
</tr>
<tr>
<td>EE</td>
<td>epithelial erosion</td>
</tr>
<tr>
<td>SPK</td>
<td>superficial punctate keratitis</td>
</tr>
<tr>
<td>PEK</td>
<td>punctate epithelial keratitis</td>
</tr>
<tr>
<td>CCC</td>
<td>central corneal clouding (0 to 4+)</td>
</tr>
<tr>
<td>SEI</td>
<td>subepithelial infiltrates</td>
</tr>
<tr>
<td>FB</td>
<td>foreign body</td>
</tr>
<tr>
<td>EKC</td>
<td>epidemic keratoconjunctivitis</td>
</tr>
<tr>
<td>GPC</td>
<td>giant pupillary conjunctivitis</td>
</tr>
<tr>
<td>PVD</td>
<td>posterior vitreous detachment</td>
</tr>
<tr>
<td>AVD</td>
<td>anterior vitreous detachment</td>
</tr>
<tr>
<td>PHPV</td>
<td>persistent hyperplastic primary vitreous</td>
</tr>
<tr>
<td>RP</td>
<td>retinitis pigmentosa</td>
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</table>

**Pharmaceutical**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>DPA</td>
<td>diagnostic pharmaceutical agent</td>
</tr>
<tr>
<td>TPA</td>
<td>therapeutic pharmaceutical agent</td>
</tr>
<tr>
<td>OTC</td>
<td>over the counter</td>
</tr>
<tr>
<td>BAK</td>
<td>benzalkonium chloride</td>
</tr>
<tr>
<td>STAT</td>
<td>immediately</td>
</tr>
<tr>
<td>c</td>
<td>with</td>
</tr>
<tr>
<td>s</td>
<td>without</td>
</tr>
<tr>
<td>prn</td>
<td>as needed</td>
</tr>
<tr>
<td>ut. disct.</td>
<td>as directed</td>
</tr>
<tr>
<td>h</td>
<td>hour</td>
</tr>
<tr>
<td>hs</td>
<td>hour before sleep/at bedtime</td>
</tr>
<tr>
<td>d</td>
<td>day</td>
</tr>
<tr>
<td>q</td>
<td>every</td>
</tr>
<tr>
<td>qh</td>
<td>every hour</td>
</tr>
<tr>
<td>qd</td>
<td>every day</td>
</tr>
<tr>
<td>qod</td>
<td>every other day</td>
</tr>
<tr>
<td>bid</td>
<td>twice a day</td>
</tr>
<tr>
<td>tid</td>
<td>three times a day</td>
</tr>
<tr>
<td>qid</td>
<td>four times a day</td>
</tr>
<tr>
<td>ac</td>
<td>before eating</td>
</tr>
<tr>
<td>po</td>
<td>by mouth</td>
</tr>
<tr>
<td>sol</td>
<td>solution</td>
</tr>
<tr>
<td>susp</td>
<td>suspension</td>
</tr>
<tr>
<td>ung</td>
<td>ointment</td>
</tr>
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<td>tab</td>
<td>tablet</td>
</tr>
<tr>
<td>caps</td>
<td>capsule</td>
</tr>
<tr>
<td>gtt</td>
<td>drop (guttae)</td>
</tr>
<tr>
<td>sig</td>
<td>label</td>
</tr>
<tr>
<td>#</td>
<td>number (i.e., number of tabs)</td>
</tr>
</tbody>
</table>
Infectious Control Program and Standard Operating Procedures for the University of Houston College of Optometry
University Eye Institute
Nick Holdeman, O.D., M.D.
Chief of Medical Services
Director, University Eye Institute
The following document is an Infectious Control Program for the University of Houston College of Optometry. The contents have been approved by the University Environmental and Physical Safety Department and the UHCO college administration. These policies and procedures apply to all students, staff and faculty participating in either the professional program or areas of research.

Each individual should be knowledgeable of the Universal Precautions established by the Centers for Disease Control (pages 1, 2, 3) and comply with the laboratory safety guidelines (page 4). Only certain materials should be introduced into the infectious waste stream while other materials are specifically prohibited from being placed into the infectious waste containers (page 6). Only specified containers will be utilized for infectious waste materials and must conform to Federal standards (page 7). Biohazard bags must be properly handled and sealed (page 8). Sharp objects present a serious potential hazard and special consideration for these items are detailed (page 8 & 9). Personal protective equipment will be supplied by the College and located in key areas throughout the school (page 9 & 10).

Education and training related to this aspect of health care will be provided by the University of Houston to each faculty, staff and student associated with the College of Optometry (page 12 & 13). Should an accident occur it must be formally documented and reported (page 13). Lastly, routine hygiene practices are discussed (page 14) which help to prevent the spread of communicable disease.
Infectious Control Program and Standard Operating Procedures for the University of Houston College of Optometry
Nick Holdeman, O.D., M.D.
Chief of Medical Services

Introduction

The purpose of this document is two-fold: (1) To establish uniform standards for safely handling blood, body fluids and body tissues. (2) To ensure that information regarding the potential hazards of all chemicals used within the College of Optometry is transmitted to employees of the College.

It is the policy of the College of Optometry that faculty, staff and students who must handle blood, body fluids, body tissues, or hazardous chemicals exercise extreme caution. Appropriate safeguards, work practices, and protective equipment shall be utilized to minimize exposure and to prevent infections. Individuals who could potentially come in contact with blood, body fluids, body tissues or hazardous chemicals in any manner will be required to adhere to an established set of operating procedures. Infectious waste may contain organisms such as Hepatitis B virus, AIDS virus, and other disease-causing agents. These infectious agents may be present in the waste generated from the clinics and/or research facilities. The recognition of the potential risk of exposure and an understanding of the methods for minimizing that exposure are important in ensuring the safe handling and disposal of these materials. It is also important to develop safe working practices and to implement methods for safe spill cleanup as well as for treatment of personnel that may be exposed to infectious waste.

Universal Blood and Body Fluid Precautions

Because the potential for infection from any patients' blood and body fluids cannot be known, blood and body fluids precautions recommended by the Centers for Disease Control
(CDC) should be adhered to for all patients and for all specimens submitted to the laboratory. These following precautions, called "UNIVERSAL PRECAUTIONS," should be followed regardless of the patient's infectious status.

UNIVERSAL PRECAUTIONS

1. Routinely use barrier protection to prevent skin and mucous membrane contamination with blood or body fluids for all patients and specimens.

2. Wear gloves when:
   (a) touching blood and body fluids including routine laboratory work and phlebotomy.
   (b) touching all laboratory specimens and tissues.
   (c) touching mucous membranes and non-intact skin of all patients.
   (d) handling items contaminated with blood or body fluids, including specimen containers, laboratory instruments, countertops, and etc.
   (e) performing venipuncture, arterial puncture, skin puncture, and other vascular access procedures.

3. Change gloves between each patient.

4. Wear a mask and eye covering during procedures that are likely to generate droplets of blood or body fluids to prevent exposure of the mucous membranes of the mouth, nose, and eyes.

5. Wear a lab coat or other covering when there is potential for splashing or spraying blood or body fluids.

6. Wash hands or other skin surfaces thoroughly and immediately if contaminated with blood or body fluids.

7. Wash hands immediately after gloves are removed.
8. Take extraordinary care to avoid accidental injuries caused by needles, scalpels, laboratory instruments, etc. when performing procedures, cleaning instruments, handling sharp instruments and disposing of used needles.

9. Place needles, skin lancets, scalpels, and other sharp items into a puncture resistant biohazard container for disposal. The container should located as close as possible to the work area.

10. To prevent needle stick injuries, needles should not be recapped, purposely bent, cut, broken, removed from disposable syringes, or otherwise manipulated by hand.

11. Place all reusable sharps into a puncture resistant container for transport to the reprocessing and disinfection area.

12. Minimize the need for mouth to mouth emergency recomposition procedures. Mouth pieces, resuscitation bags, and other ventilation devices should be used routinely.

13. Take care to minimize the formation of droplets, splatters, splashes, and spills of blood or body fluids.

14. Clean all surfaces exposed to blood and body fluids with a detergent solution followed by decontamination with an appropriate EPA approved germicide.

15. Health care providers and laboratory workers with exudative lesions or seeping dermatitis should refrain from all patient contact and from handling patient care equipment and patient specimens until the condition resolves. Alternatively, skin lesions may be covered with an occlusive bandage to prevent contamination. Pregnant women are not known to be a greater risk to contracting blood-born infections than other laboratory workers. However, if HIV infection develops during pregnancy, the infant is at risk of infection by perinatal transmission. Therefore, pregnant laboratory workers should be especially aware of these universal precautions.
Special precautions for laboratories:

1. Laboratory space should be allocated to minimize crowding which may contribute to laboratory accidents.

2. Good laboratory practices should be followed. Eating, drinking, and smoking should not be permitted in the laboratory.

3. Adequate and conveniently located biohazard containers for disposal of contaminated materials should be provided.

4. Adequate decontaminated containers for reusable supplies should be provided.

5. Facilities for hand washing should be provided in each laboratory area.

6. Only authorized personnel should be allowed in the laboratory. Casual visitors should not be admitted. Non-laboratory personnel should be closely supervised and should use appropriate protective measures to ensure that they do not cause a hazard to themselves or to the laboratory staff.

7. Monitoring compliance is a major responsibility of the management of the laboratory. The necessary educational, monitoring, and remedial programs should be defined, documented in writing to the Chief of Medical Services, and rigorously enforced.

Definitions

Antiseptic - A chemical used on the skin to inactivate infectious agents.

Autoclave - Steam sterilizer used to decontaminate waste materials.

Body Fluids - Fluids that have been recognized by the CDC as directly linked to the transmission of disease especially HIV and/or HBV to which universal precautions apply. These fluids include blood, semen, blood products, vaginal secretions, cerebral spinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, and concentrated HIV or HBV viruses. Technically tears, perspiration, urine, and feces, are not considered infectious agents unless they are contaminated with blood; however, for our purposes, these products will be handled in the same manner as the CDC infectious fluids.
Disinfectant - A chemical such as bleach or phenol that inactivates infectious agents. Contact times are dependent upon the type of agent being used.

Exposures - All procedures or other job related tasks that involve any degree of potential for mucous membrane or skin contact with blood, body fluids, or tissues, or a potential for spills or splashes of same. The absorption and adsorption of potentially hazardous chemicals is also considered an exposure. All exposures shall be considered to carry the same degree of risk and therefore will be subject to the regulations set forth in this policy.

Face Mask or Respirators - Dust or mist-type respirators are suitable for most cleanup operations when there is danger of aerosol formation.

Gloves - Neoprene, PVC or latex gloves are recommended for most tasks. Disposable surgical gloves or plastic gloves may also be used.

Health Care Worker - An employee of a health care facility including, but not limited to, nurses, physicians, optometrists, research laboratory scientists, phlebotomists, medical technicians, housekeepers, and others whose work may involve direct contact with body fluids from living individuals or corpses.

Infectious agent - An organism (bacterial, virus, etc.) which causes disease.

Phlebotomist - A phlebotomist is any health care worker who draws blood samples.

Protective Clothing - Disposable coveralls and shoe covers are appropriate for cleanup operations. These should be liquid repellent.

Universal Precautions - The term "universal precautions" refers to a system of infectious disease control which assumes that every direct contact with body fluids is infectious and requires every employee exposed to direct contact with body fluids to be protected as though such body fluids were infected. Therefore, universal precautions are intended to prevent health care workers from parenteral, mucous membrane, and non-intact skin exposures to blood born pathogens.
Untreated biomedical waste - Any waste capable of inducing infection due to contamination with infectious agents from a biomedical source including, but not limited to, a medical practitioner, clinic, medical laboratory, or animal laboratory.

Proper Packaging and Contents

The following materials are considered by the Environmental Protection Agency (EPA) and the College of Optometry waste management agent, to be infectious waste: isolation wastes, cultures and stocks of etiological agents, blood and blood products (bulk blood greater than 100 mls) pathological wastes, contaminated laboratory wastes, sharps, (syringes, needles, scalpels, and etc.) contaminated animals, body parts, animal bedding and/or animal waste, pharmaceuticals and drugs.

Chemotherapeutic related waste may, under some circumstances, be handled by Waste Management Incorporated (WMI) granted they meet all of the specifications and requirements of OSHA, the EPA, and WMI. Should the Collège of Optometry generate any chemotherapeutic related waste, the Chief of Medical Services must be notified prior to its disposal.

The following materials may NOT be placed into containers destined for disposal at WMI.

A. Any material possessing the characteristics of, or containing materials regulated for, flammability, corrosivity, reactivity or EP toxicity. This includes aerosol cans and compressed gas canisters even when empty.

B. Any materials regulated by the Nuclear Regulatory Commission and/or the Department of Transportation as radioactive.

C. Any number of drugs, narcotics and other pharmaceuticals that are subject to regulation by FDA, DEA, or other enforcement or regulatory agencies. In cases of disposal of these materials, custody and witness destruction by personnel from these agencies is mandatory. WMI will handle destruction of such materials on a case-by-case basis.
It is important to remember that if waste material has more than one characteristic, it is regulated by virtue of the most hazardous characteristic that the material possesses.

Only certain types of containers will be used for the packaging, storage, and transportation of the untreated infectious waste from the point of generation to the incineration facility. It is understood that WMI will supply to the College of Optometry boxes, bags, etc., that meet or surpass all state and federal waste disposal regulations. Infectious waste poses the greatest hazard to personnel when it is released from its container. Infectious waste should always be packaged to prevent exposure to the people who must treat or dispose of it. Waste may be packaged in 3ml plastic bags and in rigid containers. Infectious waste containers should never be compacted or treated in such a way that they may break and release the waste into the environment. Careful handling of all infectious waste to prevent spills will also prevent exposure of personnel to possible infectious agents. Infectious waste should not be allowed to accumulate. If a significant delay in collection or treatment is anticipated it should be stored in cool conditions.

In general, all waste will be packaged as follows:

1. Form the standard corrugated carton into a box by unfolding; the bottom will then lock into place. Place the 3 ml. liner in the box with the upper part folded over the edges.

2. Waste will be placed into this lined, preformed standard corrugated carton. Small bags may be used and then placed into the box to completely fill the container. Do not compact the waste. Be sure, while packaging, that bags are oriented with their taped/tied ends on top.

3. Tape or tie the outer liner when ready for disposal.

4. Fold the top flaps in the carton completing the box and seal securely with water resistant plastic tape (minimum of 3 inches wide).

5. Mark the box in conformance with state statutory requirements. The box must have either the universal biohazard symbol or the words infectious wastes present. WMI will not accept any packages which are leaking, odiferous, overweight, improperly packaged, or otherwise off specification.
All UHCO employees and staff must pack the bags in boxes with safety in mind and to minimize handling as much as possible. One should not attempt to stuff a bag of waste inside another bag in order to achieve double bagging. This act may needlessly expose the handler and is especially true if the bags are heavy or contain items with sharp edges. Employees should, instead, place single bagged waste into a WMI box that has been lined with the second bag. One should also avoid the tendency to tamp down on the bags for more efficient packing into the disposal box. It is recommended that all handlers wear protective gloves, masks and/or goggles at all times to reduce the potential risk due to aerosolization. One should also be especially careful to adhere to the weight limits as an excessively heavy box can be difficult to handle. WMI has established a safe weight of 40 lbs as a maximum.

The most hazardous of the categories of infectious waste is generated by sharp objects. These wastes can penetrate containers and cause cuts, punctures, and scratches to personnel, thus establishing a route of entry for microorganisms. Consequently, all sharps should be contained for storage, transportation, and treatment in rigid, leak and puncture resistant containers which have closing mechanisms or are very tightly lidded. The rigid sharp container should be red and labeled with the biohazard symbol. These should be placed in the appropriate biohazard bags and WMI boxes.

All plastic bags used for containment of medical waste should be red or red-orange and clearly identified with the biohazard symbol. The words "danger" and "infectious waste" should appear in English and Spanish. The Federal Medical Waste Tracking Act requires that the College of Optometry must contain infectious fluids in quantities greater than 20 cubic centimeters in packaging that is break resistant and tightly lidded or stoppered before placing into a red biohazard bag.

SPECIAL CONSIDERATIONS FOR SHARP INSTRUMENTS (IE. NEEDLES, SCALPELS, GLASS SLIDES, LANCETS, ETC.)

1. Needles should not be recapped, purposely bent or broken by hand, removed from disposal syringes, or otherwise manipulated by hand.
2. After their use, disposal syringes and needles, scalpel blades, and other sharp items should be placed in puncture resistant containers for disposal.

3. Sharp containers shall be easily accessible to personnel needing them and located in all areas where needles are commonly used, including the emergency and minor surgery room, teaching laboratories, and the medical clinic laboratory.

4. These containers should also be located in any other setting where blood is drawn and needles are used.

5. It shall be the direct responsibility of the faculty member and/or medical technician to monitor the sharp boxes in their particular area and to notify the Chief of Medical Services when these boxes require disposal and new boxes are needed.

6. All employees and students shall be informed of the meaning of the various biohazard tags and boxes for disposal. They shall also be instructed to use double bagging where puncture or outside contamination is likely.

**Treatment and Teaching Areas**

The College of Optometry shall limit activities that may have exposure possibilities to only a few well designated areas within the College of Optometry building. These areas will be well recognizable to all faculty, students and employees by biohazard stickers which will be placed on the entering doors and biohazard labels which will be placed on disposal receptacles within the room. The following personnel protective measures shall be provided in these rooms.

A. Gloves - the use of gloves will vary according to the procedure involved. The use of disposable gloves for indicated procedures has been previously outlined within this policy manual (page 2). No gloves shall be used if they are peeling, cracked, or discolored, or if they have punctures, tears, or other evidence of deterioration. Surgical and examination gloves shall not be washed or disinfected for reuse. However, general purpose utility or rubber gloves worn by maintenance, housekeeping and other non-medical personnel may be decontaminated and reused.

9
B. Gowns - gowns or lab coats are required when splashes to skin or clothing with body fluids is likely to occur.

C. Mask and eye protectors - the use of masks and protective eye wear is required when contamination of mucosal membranes is likely to occur. They are not required for routine care.

D. Resuscitation equipment - pocket masks, resuscitation bags, or other ventilation devices shall be provided in strategic locations. This equipment will minimize a need for emergency mouth to mouth resuscitation.

Personal protective equipment as described above shall be used in performing invasive procedures to avoid exposure. Gloves are required for processing body fluids specimens in all laboratories. Masks and protective eye wear are required when the workers mucosal membranes may come in contact with body fluids. Persons performing or assisting in any postmortem procedure are required to wear personal protective equipment as noted above to avoid exposure to body fluids.

Housekeeping and Staff

The major means of protection against infection is to prevent entry of potentially infectious microorganisms through the skin. All cuts and abrasions should be kept covered with bandages, gloves, or other occlusive dressings. If unbroken skin is exposed to infectious waste or chemicals, a thorough washing with soap and water is the most effective method of preventing infection. If cuts or abrasions are present, washing with soap and water followed by application of an antiseptic are effective in minimizing the risk of infection. Cuts or puncture wounds caused by handling of infectious sharps may require more intensive treatment and should be referred to the Chief of Medical Services for evaluation and treatment. It is also understood that housekeeping services shall keep all education facilities, passage ways, store rooms, service rooms, and all clinical facilities clean and orderly and in a sanitary condition. The floor of every workroom shall be maintained in a clean, and in so far as possible, dry condition. Schedules of cleaning shall be as
frequent as necessary according to the area of the institution, type of surface to be cleaned, and the amount and type of soil present. Chemical germicides that are approved for use as hospital disinfectants and are tuberculocidal when used at recommended dilutions shall be used to decontaminate spills of blood and other body fluids following the initial cleanup. Should accidental spills of infectious waste occur, the waste material should be cleaned up as soon as possible. Cleanup can be done by personnel with appropriate personal protective equipment.

If blood, blood products, tissues or microbiological cultures have been spilled, the area should be decontaminated with a hypochlorite solution (a 1:5 dilution of household bleach and water) for approximately 30 minutes. Following this decontamination process, the waste can be placed in appropriate biohazard containers for disposal. The employee must always wear gloves and never handle infectious waste with bare hands.

If the spilled waste does not contain blood contaminated fluids or cultures it may be picked up, placed in marked containers, and the area cleaned with any industrial detergent based disinfectant. (Lysol, Pine Sol). Personnel must wear gloves to protect their hands and should place the spilled material and the cleanup materials into appropriate biohazard containers.

The College of Optometry shall identify all employees at substantial risk of directly contacting infectious wastes and body fluids. All such employees shall be informed of Hepatitis B vaccinations, in amounts and at times prescribed by standard medical practice.

The College of Optometry shall also incorporate the use of disposable linens such that linen soiled with body fluids shall be handled as little as possible and with minimum agitation to prevent contamination of the person handling the linen. All soiled linen shall be bagged at the location where it is used and shall not be sorted or rinsed in the patient areas. Soiled linen shall be placed and transported in bags that prevent leakage. After removing gloves, hands and other skin surfaces shall be washed thoroughly and immediately after contact with body fluids.
Employee Training, Education and Record Keeping

The University of Houston shall establish an initial and periodic training program for all individuals exposed to blood, body fluids, or body tissues. Training shall be provided by members of the College of Optometry and Environmental and Physical Safety Department. All high risk health care workers shall receive education on precautionary measures, epidemiology, modes of transmission and prevention of HIV/HBV. Health care workers shall be counseled regarding possible risk to the fetus from HIV/HBV and other associated infectious agents. In addition, such high risk workers must receive training regarding the location and proper use of personal protective equipment. They shall be trained concerning proper work practices and shall understand the concept of "universal precautions" as it applies to their job descriptions. They shall be trained regarding color coding or other methods used to designate contaminated articles or infectious waste. Where tags are used, training about tags and precautions to be used in handling contaminated articles or infectious waste will be discussed. Workers shall receive training about procedures to be used if they are exposed to needle sticks or to body fluids.

No faculty, staff, or students shall engage in any task requiring the handling of blood or other infectious agents before receiving training pertaining to the work practices and protective equipment required for that task.

Each faculty, staff and/or student should receive training and education in regard to the following:

1. The appropriate actions to take and persons to contact if unplanned tasks involving blood, body fluids or body tissues are encountered.
2. Types of protective clothing and equipment generally appropriate for handling specimens and understanding the basis for selection of clothing and equipment.
3. How to properly use, remove, handle, decontaminate, and dispose of contaminated clothing and equipment and where such protective clothing and equipment is kept. Corrective actions to take in the event of spills, personal exposure to fluids, or the medical monitoring recommended in cases of suspected parenteral exposure.
Training records shall be documented indicating the dates of training sessions along with the names of all persons conducting the training and the names of all those receiving training. These training records shall be maintained for at least 30 years.

**Accident Reporting**

The College of Optometry is committed to maintaining a safe academic, working and patient environment that is free of hazardous conditions for students, employees, patients and visitors. However, it is inevitable that despite the University's best efforts, accidents may occur. When used in reference to a task requiring the handling of blood, body fluids, or body tissues, an accident shall be defined as:

A. Any incident where blood, body fluids, or body tissues are inhaled or ingested or come in contact with an individual's mucous membranes or open wound.

B. Any incident where an item, which has been in direct contact with blood, body fluids, or body tissues, (e.g. glass slides, pipettes, scalpels etc.) causes an injury which results in a break of the skin.

C. Any other incident which in the opinion of the individual, significantly increases the likelihood that he/she was exposed to HIV.

Should a faculty, staff, or student member of the College of Optometry incur an injury while performing a task requiring the handling of or exposure to infectious tissues, he or she should report immediately to the Chief of Medical Services, the University Health Center, or other appropriate medical facility for evaluation and treatment if the need is indicated. The Environmental and Physical Safety Department must be notified of the incident as soon after occurrence as possible. An accident report form must be completed by the appropriate department supervisor and a thorough investigation of the accident will be conducted. If the faculty, staff, or student member is injured by body tissues of another individual, this individual should accompany the injured party for evaluation. This evaluation will better enable medical personnel to determine the possibility of the second individual passing infectious agents to the injured party.
Hygiene Practices

The following hygiene practices should be adhered to by all faculty, students and staff of the College of Optometry:

1. Hands should be thoroughly washed with soap and water even when gloves have been worn and performing tasks requiring that blood, body fluids, or body tissues be handled after each patient and before each patient.

2. Any equipment which has come in contact with body secretions must be sterilized after contact has occurred if subsequent use of that equipment is planned.

3. Clothing that has become contaminated with body fluid should be decontaminated before laundered. Soaking contaminated clothing in a 1:10 solution in chlorine bleach and water for at least 30 minutes prior to washing is one suitable means of decontaminating clothing (color may be affected).

4. Laboratory personnel must remove laboratory clothing before going to non-laboratory areas.

5. Work surfaces shall be decontaminated with an appropriate chemical germicide after procedures are completed, when surfaces are overtly contaminated and at the end of each working day. A 1:10 solution of chlorine bleach and water is one acceptable chemical germicide.

6. Eating, drinking, smoking and applying cosmetics will not be permitted in the laboratory and patient care areas.

Enclosures

1. Infectious wastes handling precautions
2. Biohazard symbol
3. Accident report forms
4. Pictorial outline of recommended method for securing red biohazard bags
<table>
<thead>
<tr>
<th>Health</th>
<th>Procedures Handling</th>
<th>Special Handling</th>
<th>Composition</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data</td>
<td>Procedures Handling</td>
<td>Special Handling</td>
<td>Composition</td>
<td>Level</td>
</tr>
</tbody>
</table>

**Categories:**
- Health
- procedures handling
- special handling
- composition
- Level

**Note:**
- Health and procedures handling are related to the handling of data.
- Special handling is related to the handling of composition.
- Level indicates the level of handling or composition.

**Examples:**
- Infections
- Waste handling precautions
Symbol for Biological Hazard
Employee Accident Report Forms

Instructions

ALL FORMS MUST BE TYPED

This report packet supplies forms for the mandatory documentation of an injury or illness potentially subject to a coverage claim through Workers’ Compensation. Mandatory forms from this packet should be completed and returned by the supervisor according to the instructions below. The typed forms should be returned within 24 hours in order to meet state stipulated deadlines. Failure to properly complete and submit necessary forms on a timely basis may delay medical and salary benefits to the injured employee.

There are four (4) forms included in this packet. The first form described is mandatory. Depending on the specific circumstances of the accident being reported, three other forms may also be required. The forms included with this packet are:

1. The “Employers First Report of Injury or Illness”, (TWCC-1S). This mandatory form must have lines 1-40 and line 52 completed. The information requested on lines 13 and 14 should be provided only if a physician was seen as a result of the accident; if no physician was seen type "NONE" on line 13 and leave line 14 blank. If the supervisor suspects that the employee will not return to work the next working day (line 26), he/she may hold the forms one additional day to confirm the employee's absence. Do not mail this form to the address printed at its top; it should be sent to Environmental and Physical Safety at the mail code shown below.

2. If lost time is anticipated as a result of the incident, then the “Employee Election Form”, (C-80-9-93), must be completed by the employee.

3. If there were witnesses to the accident, a “Witness Report” should be completed by each witness.

4. The "Authorization for Release of Information" (Form 24-016-C) must be completed by the employee if medical treatment has or most likely will be rendered. This form allows the Attorney General Workers' Compensation Division to request and receive medical information concerning the injured employee.

If you have any questions or need additional copies of this packet, contact Environmental and Physical Safety at 743-5858.

QUESTIONS? CALL 743-5858

RETURN ALL FORMS TO: EPSD-1852

EPSTDWC: 10/6/95
# EMployer's First Report of Injury or Illness

<table>
<thead>
<tr>
<th>1. Name (Last, First, M.I.)</th>
<th>2. Sex</th>
<th>15. Date of Injury (m-d-y)</th>
<th>16. Time of Injury</th>
<th>17. Date Lost Time Began (m-d-y)</th>
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<tr>
<th>3. Social Security Number</th>
<th>4. Home Phone</th>
<th>5. Date of Birth (m-d-y)</th>
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<th>6. Does the Employee Speak English?</th>
<th>If No, Specify Language</th>
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<td>YES □ NO □</td>
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<th>7. Block no longer used</th>
<th>8. Block no longer used</th>
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<tr>
<th>9. Mailing Address</th>
<th>Street or P.O.Box</th>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
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<tr>
<th>10. Marital Status</th>
<th>Married □ Widowed □ Separated □ Single □ Divorced □</th>
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<th>11. Number of Dependent Children</th>
<th>12. Spouse's Name</th>
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<tr>
<th>13. Doctor's Name</th>
<th>14. Doctor's Mailing Address (Street or P.O.Box)</th>
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<th>State</th>
<th>Zip Code</th>
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<tr>
<th>30. Date of Hire (m-d-y)</th>
<th>51. Was employee hired or recruited in Texas?</th>
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<tr>
<td></td>
<td>YES □ NO □</td>
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<tr>
<th>32. Length of Service in Current Position</th>
<th>33. Length of Service in Occupation</th>
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</thead>
<tbody>
<tr>
<td>Months</td>
<td>Years</td>
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<tr>
<td>--------</td>
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<tr>
<th>34. State Payroll Classification Code</th>
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<tr>
<th>35. Occupation of Injured Worker</th>
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<thead>
<tr>
<th>36. Rate of Pay at this Job</th>
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<tbody>
<tr>
<td>$ Hourly</td>
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<tr>
<th>37. Full Work Week is:</th>
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<tr>
<td>Hours</td>
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<th>38. Last Paycheck was:</th>
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<tr>
<th>39. Is employee an Owner, Partner, or Corporate Officer?</th>
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<tbody>
<tr>
<td>YES □ NO □</td>
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<table>
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<tr>
<th>40. Name and Title of Person Completing Form</th>
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<tbody>
<tr>
<td>Claim Coordinator</td>
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<table>
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<tr>
<th>41. Name of Agency</th>
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<tbody>
<tr>
<td>University of Houston</td>
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<table>
<thead>
<tr>
<th>42. Agency Mailing Address and Telephone Number</th>
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</thead>
<tbody>
<tr>
<td>4800 Calhoun Street or P.O. Box</td>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston</td>
<td>TX</td>
<td>77204-1852</td>
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<thead>
<tr>
<th>43. Agency Location Code</th>
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<tbody>
<tr>
<td>1 0 0 / 7 3 0 / 0 0 0</td>
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<table>
<thead>
<tr>
<th>Name of Location</th>
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<tbody>
<tr>
<td>Main Campus</td>
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<table>
<thead>
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<th>44. Federal Tax Identification Number</th>
<th>45. Primary Standard Industrial Classification Code (SIC)*</th>
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<tbody>
<tr>
<td>746001399 (4 digit)</td>
<td>8221 (4 digit)</td>
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<tr>
<th>46. Specific SIC Code*</th>
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<tr>
<th>47. Computer Agency Code</th>
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<tr>
<td>7 3 0</td>
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<tr>
<th>48. Policy Number</th>
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<tbody>
<tr>
<td>TXSTATEPOL001</td>
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<table>
<thead>
<tr>
<th>49. Number of Days Sick Leave Credited to Employee on Date of Injury</th>
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<tbody>
<tr>
<td>YES □ NO □</td>
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<table>
<thead>
<tr>
<th>Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers' Compensation Claim Coordinator Date</td>
</tr>
</tbody>
</table>
STUDENT / VISITOR ACCIDENT REPORT FORM

University of Houston

(To Be Completed By Individual Involved in Accident)

1. Name ______________________ Social Security No. ______________________
2. Student _________ Visitor _________
3. Address ______________________ City _________ Zip _________
4. Home Telephone No. (______) _________ Work Telephone No. (______) _________
5. Age _________ Sex _________ Speak English? Yes __________ No _________

6. Date of Accident __________ Month _________ Day _________ 19 _________ Day of Week _________ Hour of Day _________
7. Place where accident occurred (a) Premises ______________________ (b) State ______________________
   (c) Town ______________________ (d) County ______________________
   (e) Zip ______________________

8. Describe fully how accident occurred; state what student/visitor was doing at the time:

   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

9. Names and Addresses of Witnesses:

   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

10. If injured, Describe Injury or Illness in Detail:

    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________

    (a) Indicate part of body affected:

11. Name and Address of Physician ______________________

12. Name and Address of Hospital ______________________

13. Probable Length of Disability ______________________

Date of this report __________ Month _________ Day _________ Year _________

Completed by ______________________

Once completed, please return to the Environmental & Physical Safety Department, University of Houston, 4211 Elgin, #17-GEN, Houston, TX 77204-1852 (UH Mail - EPSD-1852). If you have questions, please call 713/459-4271. 743-5858

/tp Revised 02/13/90
icles at point of generation which are then transported to a boxing area, remember to minimize handling as much as possible. For example, do not attempt to stuff a bag of waste inside another in order to achieve double bagging. This may needlessly expose the handler and is especially true if the bags are heavy or contain items with sharp edges. Place single bagged waste into a WMI box that has been lined with the second bag.

Also, handlers may encounter difficulties at times in fitting full red bags into the boxes. Avoid the tendency to tamp down on the bags for more efficient packing. We recommend handlers wear protective gloves, masks and goggles at all times to reduce the potential of risk due to aerosolization.

We recommend the bags be securely closed, as illustrated below, to prevent leakage or expulsion of solid or liquid wastes during storage, handling and transport.

Be especially careful to adhere to the weight limits set by your local sales representatives. Although you may feel that it is more efficient to load a box with as much as possible, an excessively heavy box can make handling difficult. Possible injury to your employees as well as ours can be avoided by maintaining safe weights with 40 lbs. as a maximum. Also, exceeding the weight limits established may result in additional charges.

Prevent Back Injury

Eight out of ten Americans will experience low back pain at some point in their lives. Most injuries occur as a result of using the back improperly. Poor posture, being overweight, and weak, flabby abdominal muscles can strain the low back and make it vulnerable to injury.

Back sprains or strains occur when the back muscles or ligaments are overstretched or torn. Although sprains and strains can certainly happen due to an accident, they most commonly result from improper bending, lifting, or sitting. Using good body mechanics during all activities of daily living can prevent most back strains and sprains.
I the undersigned have read and understand the Infectious Control Program and Standard Operating Procedures for the University of Houston College of Optometry. I realize the importance of controlling infectious waste and I am aware of the potential hazard for serious illness associated with the improper handling of these materials. I understand the costs associated with the post-exposure follow-up testing and vaccination will be covered by applying for Workers Compensation.

For the purposes of qualifying for workers' compensation benefits, the law requires that an employee who claims work-related exposure to HIV infection must provide a written statement of the date and circumstances of the exposure. The law also requires the employee to document that, within 10 days after the exposure, the employee had a test result that indicated an absence of HIV infection.

I have had the opportunity to ask questions and I will comply with the guidelines contained within this document.

Signed

Date