

## Refraction Patient Acknowledgement Form

**This form will be retained by your Optician and added to your patient health record. A copy of this form will be provided to the College of Opticians of Ontario (COO) by your Optician.**

SECTION 1 PATIENT INFORMATION (To be completed by patient)			
Last Name	Given Name(s)		
Address			
Telephone Number			
Date of Birth (dd/mm/yyyy)	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Preferred Email (optional)			
Would you be willing to participate in a confidential survey conducted by the College of Opticians of Ontario regarding your experience? Yes <input type="checkbox"/> No <input type="checkbox"/>			

**This consultation is solely intended to determine your suitability to receive a refractive examination performed by a Licensed Optician and obtaining corrective lenses based on the results of the refraction. A refraction is not a medical examination and will not determine the presence of eye disease. Your Optician can advise you on the recommended frequency of eye exams for healthy adults.**

A copy of this form will be provided to the College of Opticians of Ontario (COO), in accordance with the College's Standard of Practice for Refraction.

Signature of Patient	Date
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SECTION 2 PATIENT HISTORY (To be completed by patient)	
Have you reviewed the attached Refraction Patient Information Material?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you currently wear prescription eyeglasses and/or contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>

SECTION 3 CONTRAINDICATIONS TO REFRACTION (To be completed by Optician)	
<b><i>If this assessment indicates a NO to any of the following questions, the patient MUST be immediately referred to an Optometrist or Physician for a complete eye examination.</i></b>	
Has the patient had a complete eye examination performed by an Optometrist or Physician in the past 365 days?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient between the ages of 19 and 65 years old?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did the preliminary evaluation of the patient indicate good eye health?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have a history clear of glaucoma?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have a history clear of strabismus?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have a history clear of diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have a history clear of cataracts?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the patient have a history clear of age-related macular degeneration (ARMD)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the patient's visual acuity correctable to at least 20/40 in each eye?	Yes <input type="checkbox"/> No <input type="checkbox"/>

SECTION 4 OUTCOME OF EYE HEALTH ASSESSMENT (To be completed by Optician)	
Did you perform a refraction on the patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was the refraction undertaken in collaboration with an Optometrist or Physician for the purpose of informing a comprehensive ocular assessment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you refer the patient to an Optometrist or Physician for a complete eye examination during the course of this eye health assessment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you dispense eyewear to the patient based on the results of your refractive examination?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**I HEREBY SUBMIT THIS PATIENT ACKNOWLEDGMENT FORM AND CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE , COMPLETE AND ACCURATE AND THAT THE REFRACTION HAS BEEN PERFORMED IN ACCORDANCE WITH THE COLLEGE'S STANDARD OF PRACTICE FOR REFRACTION**

Signature of Optician	Registration #	Date
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