GAIN
GUIDELINES AND AUDIT IMPLEMENTATION NETWORK

Appendix 2

RESIDENT'S EYE EXAMINATION REPORT

Name _____ D.O.B _____

Date of Examination: _____ Recommended review: _____

Summary of findings and guidance for care staff **OR** person /representative (**MUST BE COMPLETED**):

1. Vision

☐ Good (with or without spectacles) ☐ Impaired (some vision difficulties) ☐ Severely Impaired

2. Relevant Eye Condition and subsequent advice on care:

3. Reason(s) why all relevant ophthalmic tests were not completed (if applicable):

Visual Acuities	R	L	
Diabetic Report to G.P	Y ☐	N ☐	N/A ☐
Onward Referral Required:	Y ☐	N ☐	
Consult with resident's representatives:	Y ☐	N ☐	

Referred to: GP Ophthalmology Low Vision /Rehabilitation

Spectacles Recommended (with instructions e.g. 'worn for'):
Type of Spectacles:

Distance: _____
Near: _____
Multifocals: _____

Spectacles Received**#:** Y ☐ N ☐
Spectacles Engraved/Identifiable: Y ☐ N ☐
Staff member: _____ Date: _____

 # Staff to update the Personal Property Inventory of resident on receipt of spectacles

Examining optometric practitioner: _____ List No: _____

Practice Name or Stamp: