

## **B2 The routine eye examination**

### **Guideline**

- B2.01** The optometrist has a duty to carry out whatever tests are necessary to determine the patient's needs for vision care as to both sight and health. The exact format and content will be determined by both the practitioner's professional judgement and the minimum legal requirements.
- B2.02** The optometrist has a duty to examine patients at the most appropriate intervals in accordance with clinical needs.

### **Advice**

#### **General**

- B2.03** It is for the practitioner to satisfy him/herself that procedures are included or excluded according to the patient's clinical need.
- B2.04** A full examination should include:
- (a) Full and accurate collation of patient details. To include name, address, other relevant contact details, date of birth, and relevant details of visual needs, whether occupational, recreational or general (e.g. driving), name and address of GMP;
  - (b) Note of reasons for visit, description of onset, character and duration of symptoms, if any, and findings of all tests undertaken;
  - (c) History: to include any relevant personal or family history of an ocular or general health nature and any medication the patient is taking. Where possible, the patient should be asked to bring details of medication and dosage. Details of previous optical prescription and date of last eye examination or sight test (best estimate if date not known);
  - (d) The determination of the aided and/or unaided vision of each eye (aided vision should be accompanied by the specific prescription used);
  - (e) Assessment of habitual ocular muscle balance;
  - (f) An internal and external examination of the eye (note the requirements of a statutory sight test – see s.B2.19 below). As a minimum this will include direct ophthalmoscopy on the undilated eye. Pupil dilation and/or the use of indirect methods will be appropriate in certain circumstances where an inadequate view of the fundus would otherwise be obtained. Slit-lamp biomicroscopy will be appropriate where a detailed view of the anterior eye and adnexa is required;
  - (g) Subjective findings to establish visual acuity of each eye individually.

- B2.05** In addition to the procedures above a full examination may include:

- (a) An assessment of the patient's visual needs and visual environments;

- (b) Ocular motility assessment, convergence, pupil reflexes;
- (c) Visual field assessment on all relevant patients, especially those at risk of glaucoma. (See section D3 on Examining the patient at risk from glaucoma);
- (d) Objective refractive findings;
- (e) Binocular balancing and binocular visual acuity as appropriate;
- (f) Assessment of accommodation to determine any additions to the distance prescription, if required for intermediate or near tasks;
- (g) Intraocular pressure measurement on patients at risk of glaucoma. (See section D2 on Examining the patient at risk from glaucoma).

**B2.06** On completion of all appropriate tests, suitable advice on the findings should be given to the patient and the patient advised when to re-attend for their next routine eye examination.

**B2.07** The practitioner should conduct an examination that is appropriate to the immediate needs of the patient. The optometrist may need to justify his/her actions subsequently so that when a test that would otherwise be considered necessary for that patient cannot be carried out, the optometrist should record the reason for this on the patient record card. Please note the required elements of a statutory sight test (see paras B2.19 and B2.20).

**B2.08** It is very important to record all findings accurately during the examination. If findings are not recorded, it cannot be assumed that the relevant test has actually been carried out. (See section A9 on Patient records).

**B2.09** It should always be made clear to the patient in advance whether the examination will be carried out under the NHS or privately. Any payments for procedures in addition to the statutory sight test should be agreed with patients in advance.

### **Frequency of eye examinations**

**B2.10** The advice that follows indicates minimum re-examination intervals that are considered good practice for defined categories of patients. It also lists specific circumstances where departures from those intervals may be considered clinically necessary.

**B2.11** Contact lens wearers may need more frequent appointments (for aftercare) than at the intervals stated below. Contact lens wear will not, of itself, entitle them to more frequent NHS eye examinations than outlined in this guidance.

#### **Recommended minimum re-examination intervals**

**B2.12** Unless deemed clinically necessary, patients should not be recalled more frequently than the following intervals:

- (a) Patient aged up to 16 years, in the absence of any binocular vision anomaly or manifest refractive error – 1 year;
- (b) Patient aged under 7 years with binocular vision anomaly or corrected refractive error – 6 months;
- (c) Patients aged 7 years and over, and under 16 with binocular vision anomaly or rapidly progressing myopia – 6 months;
- (d) Patients aged 16 years and over – 2 years.

**B2.13** There are patients with relevant medical and ocular conditions for whom the following minimum re-examination intervals are recommended:

- (a) Patients over 40 with a family history of glaucoma or with ocular hypertension who are not part of a monitoring scheme – 1 year;
- (b) Patients with diabetes who are not part of a diabetic retinopathy monitoring scheme – 1 year.

#### **Clinical reasons for earlier recall**

**B2.14** Clinical circumstances may justify recalling a patient earlier than at the intervals set out above. Examples are given below:

- (a) Patients at any age with refractive error which is changing rapidly or who are at risk of such changes, e.g. newly diagnosed diabetic patients;
- (b) Other occasions when the patient is managed by the optometrist under the GOC referral rules, e.g. suspect visual field on one visit which is not confirmed on repeat or abnormal IOP with no other significant signs of glaucoma;
- (c) Patients identified in protocols as needing to be seen more frequently than above because of risk factors;
- (d) Patients with pathology likely to worsen, e.g. ARMD, cataract, corneal dystrophy, or congenital anomalies;
- (e) There may be a clinical need to examine older patients more often. Practitioners should ensure that the reason for this is clearly recorded.

#### **Patient initiated re-examination**

**B2.15** There will be patients who may present to practices at intervals earlier than those recommended, for example:

- (a) Referral by a GMP;
- (b) Patients presenting with symptoms or concerns that can only be resolved by an eye examination;
- (c) Patients who may be considered as being in a high risk group because of high myopia or aphakia (i.e. those requiring complex lenses or with corrected vision of less than 6/60 in one eye).

**B2.16** It is recognised that there will be cases when patients present to the practice with symptoms, e.g. headaches, where after examination no ocular cause can be found.

**B2.17** The situation where a patient has broken spectacles does not by itself constitute a clinical reason for re-examination.

## **Information**

### **Duty to give prescriptions**

**B2.18** Section 26(2) of the Opticians Act 1989 and the Sight Testing (Examination and Prescription) (No 2) Regulations 1989 require that immediately on completion of the examination, the patient shall be given a copy of the prescription a signed statement stating that the person does not require a prescription or that there has been no change to the patient's current prescription. The Act also requires that the statement should say if the patient is being referred to a registered medical practitioner and if s/he is being referred, the reason for the referral.<sup>1,2</sup> See also section D10, Referrals/Notifications.

<sup>1</sup> Opticians Act 1989, s.26(1)(b)(ii)

<sup>2</sup> The Sight Testing (Examination and Prescription) (No2) Regulations SI1989/1230 s.3(1)(b)

## Required content of statutory sight test

**B2.19** s 36(2) of the Opticians Act states that:

“References in this Act to testing of sight are references to testing sight with the object of determining whether there is any and, if so, what defect of sight and of correcting, remedying or relieving any such defect of an anatomical or physiological nature by means of an optical appliance prescribed on the basis of the determination”.

The regulatory background to the eye examination (whether performed privately or under the GOS) is contained in the Sight Testing (Examination and Prescription)(Number 2) Regulations,<sup>3</sup> which were made in 1989, as a result of measures contained in the Health & Medicines Act 1989.

**B2.20** The essential words relating to the sight test are these:

*(1) When a doctor or optician tests the sight of another person, it shall be his duty*

*(a) to perform, for the purpose of detecting signs of injury, disease or abnormality in the eye or elsewhere*

*(i) an examination of the external surface of the eye and its immediate vicinity,*

*(ii) an intra-ocular examination, either by means of an ophthalmoscope or by such other means as the doctor or optician considers appropriate,*

*(iii) such additional examinations as appear to the doctor or optician to be clinically necessary*

**B2.21** These Regulations also contain provisions relating to:

- the duty to issue a prescription or statement;
- exceptions to that duty;
- the particulars to be issued in a prescription or statement.

## NHS regulations

### Fees

**B2.22** The College endorses the need for fees to reflect the professional service provided. Nothing in this guidance prevents the optometrist from making appropriate charges for procedures.<sup>4</sup> However, where a sight test is funded by the NHS, practitioners are reminded that it is a breach of regulations to charge for any procedure undertaken as part of a GOS sight test in England,<sup>5</sup> Northern Ireland,<sup>6</sup> Scotland<sup>7</sup> and Wales.<sup>8</sup>

---

<sup>3</sup> The Sight Testing (Examination and Prescription) (No2) Regulations SI1989/1230

<sup>4</sup> AOP Guidance on the content of a regulation sight test is available at [www.aop.org.uk/uploaded\\_files/pdf/appendix1.pdf](http://www.aop.org.uk/uploaded_files/pdf/appendix1.pdf)

<sup>5</sup> The National Health Service General Ophthalmic Services Contracts Regulations 2008 para 16 SI 1185 of 2008

<sup>6</sup> General Ophthalmic Services Regulations (Northern Ireland) SI 436 of 2007 Schedule 1 para 13(4).

<sup>7</sup> National Health Service (General Ophthalmic Services) (Scotland) Regulations SSI 135 of 2006 (para 13(5))

<sup>8</sup> National Health Services (General Ophthalmic Services) Regulations 1986 (as amended) Schedule 1, para 9(4). SI 975 of 1986. The consolidated GOS

### **Necessity of sight testing**

- B2.23** In England, the National Health Service General Ophthalmic Services Contracts Regulations 2008 require practitioners to satisfy themselves that a sight test is necessary.<sup>9</sup> Similar provisions apply in Northern Ireland,<sup>10</sup> Scotland<sup>11</sup> and Wales.<sup>12</sup>

### **Patients with diabetes and glaucoma**

- B2.24** In England, the National Health Service General Ophthalmic Services Contracts Regulations 2008 require that every time the optometrist 'tests the sight' of a patient diagnosed as suffering from diabetes or glaucoma, s/he must inform the patient's doctor or GMP practice of the results of the test<sup>13</sup>. Similar provisions apply in Northern Ireland,<sup>14</sup> Scotland<sup>15</sup> and Wales.<sup>16</sup>

### **Equality Act 2010**

- B2.25** The Equality Act determines that everyone has the right to be treated equally and individuals are protected from unfair treatment. It makes it unlawful to discriminate, directly or indirectly, against people by virtue of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation. In particular service providers have to make 'reasonable' adjustments to their practice environment and fabric to ensure that disabled people can access their services.<sup>17</sup>

- B2.26** See also the additional recommendations for specific groups:  
*Section C1 - Examining the younger child*  
*Section C3 - Examining the adult patient with learning disabilities*  
*Section C4 - Examining the adult patient with dementia or other acquired cognitive impairment*  
*Section C5 - The domiciliary eye examination*  
*Section D2 - Examining the patient with diabetes mellitus*  
*Section D3 - Examining the patient at risk from glaucoma*

---

regulations are available at

[www.dh.gov.uk/en/Healthcare/Primarycare/Optical/DH\\_4101241](http://www.dh.gov.uk/en/Healthcare/Primarycare/Optical/DH_4101241) Accessed 6/5/11

<sup>9</sup> The National Health Service General Ophthalmic Services Contracts Regulations SI 1185 of 2008 (Schedule 1, para 1(3)(c)).

<sup>10</sup> General Ophthalmic Services Regulations (Northern Ireland) SI 436 of 2007 (para 17(4)(c)).

<sup>11</sup> National Health Service (General Ophthalmic Services) (Scotland) Regulations SSI 135 of 2006 (para 22(3)(b))

<sup>12</sup> National Health Services (General Ophthalmic Services) Regulations 1986 (as amended) s.13A(4)(c). The consolidated GOS regulations are available at

[www.dh.gov.uk/en/Healthcare/Primarycare/Optical/DH\\_4101241](http://www.dh.gov.uk/en/Healthcare/Primarycare/Optical/DH_4101241) Accessed 6/5/11

<sup>13</sup> The National Health Service General Ophthalmic Services Contracts Regulations SI 1185 of 2008 para 13(4)

<sup>14</sup> General Ophthalmic Services Regulations (Northern Ireland) SI 436 of 2007 (Schedule 1, para 14(3)).

<sup>15</sup> National Health Service (General Ophthalmic Services) (Scotland) Regulations SSI 135 of 2006 (Schedule 1 para 14(5))

<sup>16</sup> National Health Services (General Ophthalmic Services) Regulations 1986 (as amended) Schedule 1, para 10(3). SI 975 of 1986. The consolidated GOS regulations are available at [www.dh.gov.uk/en/Healthcare/Primarycare/Optical/DH\\_4101241](http://www.dh.gov.uk/en/Healthcare/Primarycare/Optical/DH_4101241) Accessed 6/5/11

<sup>17</sup> Equality Act 2010 s.20.

Other relevant sections include:

*Section A9 - Patient records*

*Section D10 – Referrals/notifications*

*Section G - Contact lens practice*

*Section K1 - Use and supply of drugs or medicines in optometric practice*

### **Additional information**

The following information is relevant to this section:

Bengtsson B The prevalence of glaucoma *Br J Ophthalmol* 1981 65, 46-49.

Burnett S et al; The implementation of prompted retinal screening for diabetic eye disease by accredited optometrists in an inner city district of North London. *Diab Med* Nov. 15 Suppl 1998 S38-43.

Chignell AH, Harle D, Tanner V, Williamson TH. Acute Posterior Vitreous Detachment. *Optom in Practice* 2000 (1) 97-102.

Coffey et al. Prevalence of glaucoma in the West of Ireland. *Br J Ophthalmol* 1993 77, 17-21.

Cordonnier M, Dramaix M. Screening for abnormal levels of hyperopia in children: a non cycloplegic method with a hand held refractor. *Br J Ophthalmol* 1998 82 (11) 1260-1264.

Cullinan TR The epidemiology of visual disability studies of visually disabled people in the Community. Health Services Research Unit, University of Kent; Report No. 28 1997

Evans J and Wormald R. Is the incidence of registerable age related macular degeneration increasing? *Br J Ophthalmol* 1996 80 9-14.

Framework for the optometric co-management of patients with cataract, College of Optometrists, 2003

Framework for the co-management of patients with diabetes, College of Optometrists, 2004

The General Optical Council (Rules relating to Injury or Disease of the Eye) Order of Council 1999 SI 1999/3267

Goss DA et al; Refractive error axial length, and height as a function of age in young myopes. *Optom Vis Sci* 1990 67(5) 332-338.

Goss DA, Wolter KL. Nearpoint phoria changes associated with the cessation of childhood myopia progression. *J Am Optom Assoc* 1999 70(12) 764-768.

Goss DA. Cessation age of childhood myopia progression. *Ophth Physiol Opt* 1987 6(2) 243-244.

Harries V et al; Visual disability among older people; a case study in assessing needs and examining services. *Journal Public Health Medicine* 1994 16(2) 211-218.

Ingram RM et al; Effect of spectacles on changes of spherical hyperopia in infants who did and did not have strabismus. *Br J Ophthalmol* 2000 84(3) 324-326.

Klein R Klein BE and Linton KL Prevalence of age related maculopathy. The Beaver Dam Eye Study *Ophthalmology* 1992 60, 933-943.

Leese GP et al; Detection of sight threatening diabetic eye disease. *Diab Med* 1996 Oct 13(10), 850-853.

Mason J et al; Optometric Screening for diabetic retinopathy: evidence and environment. *Ophthal Physiol Opt* 1996 16(4) 274-285.

Mitchell P et al. Prevalence of open angle glaucoma in Australia. The Blue Mountain Eye Study *Ophthalmology* 1996; 103, 1660-1669.

Moore B et al; A clinical review of hyperopia in young children. *J Am Optom Assoc* 1999 70(4) 215-224.

Mullvihill A et al; Outcome in refractive accommodative esotropia. *Br J Ophthalmol* 2000 84(7) 746-749.

The National Health Service General Ophthalmic Services Contracts Regulations  
2008 SI 1185 of 2008  
Opticians Act 1989  
Optometrists' Formulary  
Reidy A et al; Prevalence of serious eye disease and visual impairment in a North  
London population. *BMJ* 1998 316; 1643-1646.  
Reidy A et al; Prevalence of serious eye disease and visual impairment in a North  
London population: population based, cross sectional study. *BMJ* 1998 316: 1643-  
1646.  
Robinson R et al; Unrecognised and unregistered visual impairment *Br J Ophthal*  
1994 78 736-740.  
Roxburgh S. The conundrum of sweet hyperopia. *Br J Ophthal* 2000 84 1088-1089.  
Smeeth et al. Effectiveness of screening older people for impaired vision in a  
community setting *BMJ* 1998 316 660-663.  
Tielsch JM et al. A population based evaluation of glaucoma: the Baltimore Eye  
Survey. *Am J Epidemiol* 1991 134 1102-1110.  
Wormald et al; Visual problems in the elderly population and implications for  
services *BMJ* 1992 304: 1226-1229.  
Wormald R. Cataract Surgery-quantity and quality. *Br J Ophthal* 1999 83 889-890.  
Zadnik et al; Ocular predictors of the onset of juvenile myopia. *Invest Ophthal Vis  
Sci* 1999 40(9) 1936-1943.