

# FLINDERS MEDICAL CENTRE EMERGENCY DEPARTMENT EYE EXAMINATION SHEET

Affix patient label here

DATE .....

Place first noticed (tick one only)

Home    Work    Sport/Recreation

Other (specify) .....

**HISTORY** (briefly) .....  
.....  
.....  
.....

E.D. TIME .....  
M.O. ....  
REG CALLED (TIME).....  
PATIENT SEEN (TIME) .....  
DISCHARGE TIME .....

Place first noticed (tick one only)

Pain     Change in vision     Photophobia  
Yes No                      Yes No                      Yes No

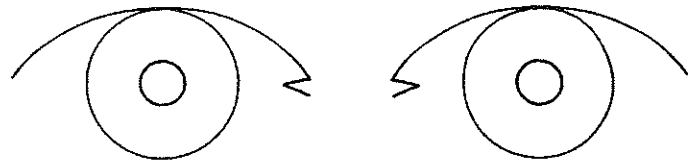
On examination is there:

Redness     Discharge     Corneal Ulceration  
Yes No                      Yes No                      Yes No

Right  
6/

**VISUAL ACUITY**

Left  
6/



### EXAMINATION

NAD N/Applicable

Periorbital Tissue .....  .....   
Lids .....  .....   
Conjunctiva .....  .....   
Sclera .....  .....   
Cornea .....  .....   
With staining .....  .....   
Eversion x 1 .....  .....  ..... x 2 .....  
Fundi .....  .....   
Pressure .....  .....

**SUMMARY/ASSESSMENT** (briefly) .....

**TREATMENT** .....

**DIAGNOSIS** .....

**FOLLOW-UP**  
 Eye O.P.D. ....  
 L.M.O. ....  
 A/E R/V .....  
 Eye Reg .....

DISCHARGED WITH/WITHOUT LETTER TO DR.                      X/RAYS   
 REFERRED WITH/WITHOUT APPOINTMENT TO  
 DIED IN EMERGENCY SERVICE                      PATHOLOGY   
 ADMIT TO HOSPITAL      CLASSIFICATION HS/PP/ <sup>WC</sup>VA  
PROVISIONAL DIAGNOSIS .....  
CLINIC ..... WARD ..... CONSULTANT .....  
DISCHARGE TIME ..... SIGNATURE M.O. ....

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