OKLAHOMA DEPARTMENT OF CORRECTIONS

MSRM 140117.01.3.5
(R-4/19)

Visual Complaints and/or Visual Acuity Testing

Subjective Data: **Allergies:** _____

Chief complaint: _____

Associated Symptoms:

❑ Trouble seeing objects	❑ Difficulty reading	❑ Blurred vision when trying to view objects from near or far	
❑ Difficulty telling colors	❑ Eye itching or discharge	❑ Gradual loss of the sharpness of vision	
❑ Foreign body sensation	❑ Eye pain	❑ Headache	❑ Frequent thirst or urination

Procedure:

1. Secure the Snellen chart to a flat surface in a well-lit room. The chart should be at a comfortable height, which may change depending on the individual's height.
2. Measure twenty feet from the chart and mark a spot facing the chart directly. (The test results will only be accurate if it is taken from this distance).
3. Stand at the twenty foot line and cover your left eye with the palm of your hand. Do not put pressure on the eye as it is covered. Starting from the top, read each row from left to right for as far down as you can still make out the letters. Note the last line on which you could correctly identify every letter. Have a nurse verify that you are reading the letters correctly.
4. Repeat the test covering your right eye this time. Do not put pressure on the eye as it is covered. Note the last row you could read with complete accuracy. The row for each eye will not necessarily be the same.

Objective Data:

Right Eye (OD)		
❑		**Unable**
❑	**E**	**20/200**
❑	**F P**	**20/100**
❑	**T O Z**	**20/70**
❑	**L P E D**	**20/50**
❑	**P E C F D**	**20/40**
❑	**E D F C Z P**	**20/30**
❑	**F E L O P Z D**	**20/25**
❑	**D E F P O T E C**	**20/20**
❑	**L E F O D P C T**	**20/15**
❑	**F D P L T C E O**	**20/13**
❑	**F P E Z O L C F T D**	**20/10**

Left Eye (OS)		
❑		**Unable**
❑	**E**	**20/200**
❑	**F P**	**20/100**
❑	**T O Z**	**20/70**
❑	**L P E D**	**20/50**
❑	**P E C F D**	**20/40**
❑	**E D F C Z P**	**20/30**
❑	**F E L O P Z D**	**20/25**
❑	**D E F P O T E C**	**20/20**
❑	**L E F O D P C T**	**20/15**
❑	**F D P L T C E O**	**20/13**
❑	**F P E Z O L C F T D**	**20/10**

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IF: *Health care provider must be called if not on site or if after clinic hours.*

- ❑ Visual acuity 20/70 or worse
- ❑ Partial or complete blindness in one or both eyes, even if it is only temporary.
- ❑ Double vision, even if it is temporary.
- ❑ Sensation of a shade being pulled over your eyes or a curtain being drawn from the side, above, or below.
- ❑ Blind spots, halos around lights, or areas of distorted vision appear suddenly.
- ❑ Sudden blurred vision with eye pain, especially if the eye is also red. A red painful eye with blurred vision is a medical emergency.

Health Care Provider: _____ **Time Notified:** _____ **Orders Received for Treatment:** ❑ Yes ❑ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions:

- ❑ Check in assessment only for health care providers visit.
- ❑ Assessment completed. Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation.
- ❑ Inmate instructed on procedure
- ❑ Inmate washed his/her hands (as they will use a hand to cover one eye at a time)
- ❑ Inmate positioned, sitting or standing, at a distance of 20 feet from the chart
- ❑ Education/Intervention: Inmate instructed to follow-up sick call if experiencing any signs and symptoms that warrant treatment. Inmate verbalizes understanding of instructions.

Progress Note: _____

Health Care Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

RN/LPN Signature/Credentials: _____ **Date:** _____ **Time:** _____

Inmate Name (Last, First) **DOC #**