COLLEGE OF
OPTOMETRISTS
OF ONTARIO

OPTOMETRIC PRACTICE REFERENCE

Standards of Practice

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The Guide to the Clinical Practice of Optometry

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A. INTRODUCTION & PURPOSE

A.1. INTRODUCTION

The College of Optometrists of Ontario is the regulatory body for the optometric profession in Ontario. Under the authority of the *Regulated Health Professions Act* and the *Optometry Act*, the College is responsible for registering (licensing) and governing optometrists in Ontario. To assist in meeting its legislated duty to protect the public interest, the College develops and publishes documents relating to optometric practice, such as the Optometric Practice Reference (OPR).

The OPR is periodically reviewed and updated in response to changes in public need, economic forces, advances in health care sciences, and statutory and regulatory requirements.

Additional administrative and clinical practice policies and guidelines not contained in the OPR are listed online: Policies & Guidelines – College of Optometrists of Ontario (collegeoptom.on.ca/resources)

A.2. REGULATORY REQUIREMENT

Health professions are required, by the legislation of the Province of Ontario, to have standards. These standards are mandatory requirements for the profession. Non-compliance with these standards could result in an allegation of professional misconduct.

A.3. STANDARDS OF PRACTICE

Professional standards describe what a consensus of prudent practitioners would do in certain circumstances. Every profession has standards of practice that come from a variety of sources such as educational programs, clinical training, evidence-informed literature, informal professional dialogue, and the decisions of a College and the courts.

In addition to writing standards into a regulation, a College may also publish documents that describe the existing generally accepted standards on recurring and/or significant issues. These publications are more valuable if they are the result of a consultation process.

The requirement to maintain the standards of practice is supported by the Professional Misconduct Regulations under the *Optometry Act*.

A.4. THE PURPOSE OF THE OPR

The OPR fulfills three key functions:

- To inform College registrants of the principles and criteria that underlie the standards of practice and behaviour of the profession.
- To assist committees of the College to carry out their work.
- To provide information to the public and patients regarding the services and behaviour that can be expected from a registrant of the College.

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B. THE PRACTICE OF OPTOMETRY

B.1. SCOPE OF PRACTICE

Ontario's *Optometry Act* specifies the scope of practice of optometry as follows:

> The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of:
>
> - disorders of refraction;
> - sensory and oculomotor disorders and dysfunctions of the eye and vision system; and
> - prescribed diseases.

B.2. AUTHORIZED ACTS

The Province of Ontario uses the concept of controlled acts to describe healthcare procedures and responsibilities that are not within the domain of the public. This forms the basis for regulation of healthcare services in the province. Fourteen such controlled acts are described in the *Regulated Health Professions Act* and each profession-specific act, such as the *Optometry Act*, specifies those that are authorized to the professional group.

While engaging in the practice of optometry, registrants are authorized, subject to the terms, conditions and limitations imposed on their certificate of registration, to perform the following:

- Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease.
- Applying a prescribed form of energy.
- Prescribing drugs designated in the regulations.
- Prescribing or dispensing for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.[1]

B.2.1. Form of Energy

When considering any emerging technology or therapy, registrants must consider whether it is within their scope of practice, whether they have the knowledge and skills to adopt it safely and effectively, that it does not compromise patient safety and that it complies with the standards of practice.

[1] https://www.ontario.ca/laws/statute/91o35

B.3. PRINCIPLES OF PRACTICE

There are several key principles that form the foundation for the optometric profession.

B.3.1. Professionally Based

Above all, the purpose of the optometric profession is to provide for the healthcare needs of patients, by placing the patient's best interest foremost. Registrants must disclose to patients any conflict of interest, such as a financial relationship with a surgical centre or other practice to which the registrant refers the patient.

B.3.2. Scientifically Based

The profession of optometry is founded on research and education in the life and vision sciences, combined with scientific and technological expertise. The College supports the use of evidence-informed techniques, instrumentation and therapies that have the support of peer-reviewed literature and professionally developed practice guidelines. As such, registrants must stay abreast of developments in evidence-informed treatments and new technologies and ensure that their patients have access to them if appropriate.

The practitioner must ensure that any procedure is supported by peer-reviewed literature, appropriate education and training, and abides by infection control principles.

B.3.3. Primary Health Care

Registrants are independent practitioners who work within Ontario's healthcare system in co-operation with other providers of related services for the ultimate benefit of patients.

B.3.4. Related to Eyes and Vision

The services generally provided in primary care optometry include:

- assessment, diagnosis, management and prevention of conditions of the eye and vision system
- treatment, correction or rehabilitation of conditions of the eye and vision system
- dispensing of eye glasses, contact lenses and low vision devices
- referral to, or shared care with, allied health professionals
- promotion of good vision and health through education

B.3.5. Accountable to the Public

The optometric profession's accountability to the public is promoted through the inclusion of public representatives on committees of the College and the College Council, which serves as

the board of directors of the College. In addition, Council meetings and discipline hearings are open to the public.

The College publishes an Annual Report on its website and provides reports to the Minister of Health and Long-Term Care.

B.4. THE REGISTRANT/PATIENT RELATIONSHIP

With reference to the registrant/patient relationship, the registrant will:

B.4.1. Be Accountable

Registrants are accountable to their individual patients and to the College for all services provided, including services related to telehealth, both personally and by others who are under their direction and supervision.

B.4.2. Act in the Patient's Best Interest and Support Patient Decision-Making

Registrants are responsible for fostering a relationship of trust with the patient and putting the patient's interest above their own.

To make informed choices about their treatment and ongoing care, patients need accurate information about the risks and benefits of treatment options. Consistent with patient-centred care, registrants give patients the information and counselling they need, and respect the choices patients make.

Registrants are expected to obtain and document informed consent where appropriate.

B.4.3. Protect Confidentiality

Historical and clinical information is gathered in a manner respecting patient privacy. All records are kept confidential and secure. Release of information requires the consent of the patient or their representative(s), except as required or allowed by law, such as the *Personal Health Information Protection Act*.

B.4.4. Be Ethical

Registrants' behaviour and business practices conform to the profession's accepted ethical standards.

B.4.5. Act with Professional Integrity and Respect

Registrants are expected to:

- comply with legislation that protects human rights and ensures safe and respectful clinical environments
- be familiar with the College's anti-discrimination policies and practice advisories and to implement them as appropriate

B.5. CLINICAL EQUIPMENT

Registrants are expected to be equipped with the instrumentation and supplies required to provide services that meet the standards of practice of the profession, and to be proficient in their use.

When registrants do not have a specific instrument, they must have arrangements in place whereby the tests may be performed elsewhere, by requisition or referral, and the results obtained for analysis and retention in the clinical record.

Registrants are expected to maintain their equipment and instrumentation in good working order, including regular re-calibration.

B.6. INFECTION CONTROL

Within all health care facilities there is a risk of transmission of infectious agents. All health care workers must mitigate that risk by being educated and proactive in the area of infection control.

Registrants must take reasonable and appropriate measures to minimize the risk of contamination and subsequent transmission of infectious agents within their professional practices.

Registrants should also follow the recommendations of their local public health units.

B.7. TELEHEALTH

Optometrists engaged in telehealth have the same ethical duties and obligations as for in-person care. They will use their judgment when deciding whether telehealth is appropriate for patients. They will communicate and collaborate effectively with patients, optometrists, and other health care providers while protecting patient privacy.

Guidance for telehealth is available on the College website.

B.8. MANAGEMENT & CONTINUING CARE

Continuing care for patients may include some or all of the following:

- patient education regarding visual status, treatment options and prognosis
- discussion and/or demonstration of potential treatment or rehabilitation options, including optical, non-optical and electronic aids and devices, lighting requirements, environmental modifications and adaptive strategies
- creation of a treatment or rehabilitation plan individualized for the patient's needs
- referral to other professionals/service providers
- reports to individuals in the patient's circle of care, when indicated

- follow-up, as needed, to assess the effectiveness of the treatment or rehabilitation plan and to monitor the patient's visual condition and needs
- re-assessment of best-corrected visual acuity and ocular health status
- history concerning any changes in vision or visual function and patient adherence to prescribed treatment
- modification of the treatment or rehabilitation plan, as indicated, to improve the effectiveness of treatment and/or to better meet patient needs and expectations

Registrants are responsible to counsel their patients in the use of any prescribed therapy and required follow-up. The prescription and appropriate counselling must be documented in the patient record. In the event that a patient experiences an adverse or unexpected response to the prescribed therapy, registrants will provide additional diagnostic and/or counselling services and, if required, make appropriate modifications to the management plan.

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C. PRACTICE MANAGEMENT

C.1. THE PATIENT RECORD

Providing optometric care involves acquiring, updating and maintaining information about each patient. Analyzing this data helps registrants develop an accurate understanding of the patient's ocular status and devise appropriate management plans. The patient record includes the patient health record of all clinical documentation and the financial record of diagnostic and treatment fees charged to and paid by the patient.

The patient record is a legal document and must be produced on request under Ontario Regulation 119/94 Part IV, S.12. It shall be made available for use in the following College processes: inquiries, complaints and reports, discipline and quality assurance.

Document the findings of the patient's initial assessment. Patient information is kept current by re-evaluation at subsequent examinations. The following information should be documented on all visits:

- proposal(s) for care and advice offered
- a description of the care rendered and recommendations for ongoing care
- indication that risks and benefits of a proposed in-office procedure or course of treatment were discussed and addressed with the patient, and that informed consent was given
- any deviations from usual care as a result of the patient's refusal or inability to cooperate, including if a test, procedure or treatment plan was recommended but declined by the patient
- specific notation if a test was performed, or a question asked, and the result was "negative" or "normal"

In addition, the patient health record shall:

- be legible and complete
- be maintained in either English or French
- include the patient's date of birth
- include details of all patient communication (both in person and electronic)
- be maintained to allow for easy identification and location of all documentation related to the provision of care

- be retained for at least 10 years following the patient's last visit or, if the patient was less than 18 years old at their last visit, for 10 years after the day they became or would have become 18

C.1.1. Referred Patients

The full complement of required clinical information may not be necessary when providing specific assessments or consultation services for referring optometrists, physicians or nurse practitioners. The same applies to patients who have not been directly referred but are already under the established care of another optometrist or ophthalmologist. In such cases, registrants will determine what is clinically necessary based on the reason for presentation.

C.1.2. Patient Access to Records

The right of patients to access the information in their record or direct that the information be transferred to another health care provider must not be limited in any manner, except as allowed by regulation. It is the right of patients to choose who provides care to them.

C.1.3. Relocation of a Patient Health Record

In situations where registrants relocate their practice or entrust the custody of records to another optometrist in another location, registrants entrusted with the maintenance of the records must make a reasonable attempt to inform patients of the location of the records. Further information is available on the College website.

C.1.4. Electronic Records

Registrants are expected to use reasonable and reliable backup systems for storing electronic records. Where patient information is stored on mobile devices or offsite in an identifiable form, the information must be encrypted.

D. ASSESSMENT

D.1. THE INITIAL ASSESSMENT

At a patient's first presentation, registrants must obtain and document the following clinical information:

- the chief concern or request
- a review of ocular or visual symptoms or experiences
- a general health history, with emphasis on eyes and vision, including medications used, allergies and applicable family history
- the occupational, educational and avocational visual environment and demands
- apparent physical, emotional and mental status, when relevant
- the measurement and description of their ophthalmic appliances including purpose and effectiveness
- a clinical examination of the patient, including the observation, examination or measurement of:
    - presenting monocular visual acuities at distance
    - presenting visual acuity at near, monocularly when clinically indicated
    - refractive status and best-corrected monocular visual acuity at distance
    - binocular vision assessment
    - pupillary function
    - intraocular pressure in adults and, when indicated, in children
    - the anterior segment
    - the posterior segment

Signs, symptoms and risk factors obtained at this initial assessment influence registrants' decisions about additional assessments (such as visual fields, colour vision, stereoacuity, sensory fusion and contrast sensitivity), the appropriate course of treatment and referral, and how often to re-evaluate a patient.

D.1.1. Emergencies

In emergency situations, it may be impractical to obtain all clinical information at the first visit. In such cases, specific assessment is appropriate. The registrant may advise the patient to seek a full comprehensive eye exam within a reasonable time frame or send a report to their primary optometrist for continuation of care.

D.2. REFRACTIVE ASSESSMENT

The refractive assessment includes determining the patient's refractive status and best-corrected visual acuities. When possible, objective and subjective refraction techniques are used to assess the refractive status of the eye at the initial visit and as often as clinically indicated afterward. Cycloplegic refraction is used when clinically necessary.

Refractive assessment alone does not provide enough information to allow a registrant to issue an appropriate prescription for subnormal vision devices, contact lenses or eye glasses. The effects of ocular and systemic health conditions, binocular vision status, and the occupational and avocational visual environment and demands must also be considered.

D.2.1. Cycloplegic Refraction

Cycloplegic refraction is indicated on the initial assessment of some children and young adults, including but not limited to those:

- with suspected clinically significant latent hyperopia
- with unexplained reduced visual acuity
- with suspected amblyopia
- who are at risk of developing amblyopia secondary to accommodative esotropia or asymmetric refractive error

D.3. BINOCULAR VISION ASSESSMENT

The initial binocular vision assessment includes, at minimum, ocular alignment and, in school-age children, accommodation. As indicated, it may also include:

- comitancy
- ocular motility
- saccadic and pursuit function
- vergence function
- consideration of etiology (congenital versus acquired disorders)
- nystagmus
- sensory function
- identification of postural adaptations

D.4. ANTERIOR SEGMENT EXAMINATION

A complete anterior segment examination must include an inspection of the following anatomical areas:

- lids/adnexa
- conjunctiva/sclera

- cornea (tear film and corneal thickness, when indicated)
- anterior chamber and angle (and gonioscopy, when indicated)
- iris
- crystalline lens

D.5. POSTERIOR SEGMENT EXAMINATION

A complete posterior segment examination must include an inspection of the following anatomical structures:

- vitreous humour
- quantitative optic nerve assessment
- macula/fovea
- retinal vasculature
- retinal tissues including posterior pole, mid-periphery and, where clinically indicated and/or possible, peripheral retina and ora serrata

Fundus photography is not considered a replacement for a complete posterior segment examination.

D.6. PHARMACOLOGIC DILATION

The situations or patient symptoms indicating that dilation is required (unless contraindicated) include:

- symptoms of flashes of light (photopsia), onset of or a change in number or size of floaters
- unexplained or sudden vision change, loss or distortion (metamorphopsia)
- the use of medication that may affect ocular tissues (e.g., hydroxychloroquine, phenothiazine, long-term steroids)
- the presence of systemic or ocular disease that may affect the posterior segment (e.g., diabetes, hypertension)
- a history of significant ocular trauma, or ocular surgery that increases risk to the posterior segment
- a history of moderate to high axial myopia
- when a better appreciation of the fundus is required (e.g., choroidal nevus, optic nerve anomaly)
- when the ocular fundus is not clearly visible through an undilated pupil (e.g., cataract)

D.7. VISUAL FIELD ASSESSMENT

Indications for visual field assessment and analysis include:

- assessment of visual disability
- assessment of patients' ability to operate a motor vehicle
- unexplained headaches
- unexplained photopsia or other visual disturbances
- use of medications with potential neuro-ophthalmic or retinal toxicity
- eyelid or anterior segment anomalies that may affect the visual field
- some retinal diseases and abnormalities
- glaucoma or risk factors for glaucoma
- diseases of the optic nerve and visual pathway
- neurological disease

Visual field screening provides a rapid assessment of the sensitivity and/or extent of the visual field to determine if a more detailed evaluation is required.

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E. PATIENT MANAGEMENT

E.1. THE PRESCRIPTION – OPTICAL

Registrants issue a prescription only after establishing a professional relationship with the patient, completing an appropriate examination and obtaining a full understanding of the relevant aspects of the patient's needs, ocular health, refractive status and/or binocular condition.

A spectacle (eye glass) prescription must be provided to the patient without request and without additional charge, regardless of whether the examination is an insured or uninsured service. Charges for additional copies of the prescription are at the discretion of the registrant.

When registrants have performed the necessary services to prescribe a specific appliance (e.g., contact lens), an appliance-specific prescription, including the parameters of that appliance, must be provided to the patient. Registrants may withhold this information pending payment for the related service.

Patients have the right to fill their prescriptions at the dispensary of their choice.

Electronic prescribing must be done securely and in an unaltered form.

E.1.1. Required Information

An optical prescription must contain information that:

- clearly identifies the prescribing registrant, including name (with degree and profession), address, telephone number, license (registration) number and signature
- includes the registrant's authentic and unaltered signature
    - electronic signatures are acceptable
- clearly specifies the identity of the patient
- specifies the date prescribed and an expiry date
- is used by a regulated professional to dispense eye glasses, contact lenses or a subnormal vision device that will provide the required vision correction for the patient

E.2. USE & PRESCRIBING OF DRUGS IN OPTOMETRIC PRACTICE

Registrants with authority to prescribe drugs can do so to manage patients with diseases and disorders of the eye and vision system.

Registrants using drugs within their practices for diagnostic and therapeutic purposes will:

- use only drugs for which they have been appropriately trained
- establish a diagnosis and management plan based upon case history, clinical findings and accepted treatment modalities
- not dispense a drug
- document the drug(s) used, including concentration (when applicable) and dosage
- provide appropriate patient counselling including:
    - general information, including management options, a description of the treatment(s), expected outcomes and normal healing course
    - specific information including any potential significant risks and complications requiring urgent or emergency care
    - how to access after-hours support and emergency care
- arrange appropriate follow-up care as indicated
- refer the patient to an appropriate health care provider when clinically indicated

E.3. THE PRESCRIPTION – DRUGS

Registrants will issue a prescription only after establishing a professional relationship with the patient, completing an appropriate examination and obtaining a full understanding of the relevant aspects of the patient's needs, ocular health, refractive status and/or binocular condition.

If registrants determine that a prescribed therapy is required, a prescription must be provided as part of the assessment without additional charge, regardless of whether the examination is an insured or uninsured service.

Patients have the right to fill their prescriptions at the pharmacy of their choice.

When it is necessary to verbally communicate a prescription for drugs to a pharmacy, the details must be fully documented in the patient record, including the name of the pharmacy and any staff members assisting in the call.

E.3.1. Required Information

All prescriptions for drugs must contain information that:

- clearly identifies the prescribing registrant, including name (with degree and profession), address, telephone number, and license (registration) number
- includes the registrant's authentic and unaltered signature
  - electronic signatures are acceptable
- clearly specifies the identity of the patient
- specifies the date prescribed
- specifies the drug name, dosage, dose form and any specific directions to the patient
- includes directions to the pharmacist such as quantity to be dispensed, refills allowed and an indication if substitutions are not permitted

E.4. DELEGATION & ASSIGNMENT

In some circumstances, registrants may order another person, who would not otherwise be authorized to do so, to perform a controlled act that is within the registrant's scope of practice. This is known as delegation, and the person performing the act(s) is known as the delegate. Registrants may also receive delegation of a controlled act that is not authorized to optometry.

There are also numerous non-controlled procedures that may still require specific training and skills. Registrants may assign one or more of these procedures to another person.

Registrants are responsible for all delegated and assigned activities within their practices and are expected to supervise them as required.

E.4.1. Delegation

Delegation will only occur after the registrant has established a formal relationship with the patient, which normally will include an interview, assessment, recommendations, if appropriate, and informed consent about any clinical investigations and proposed therapy. In some cases, when an established registrant-patient relationship already exists, delegation may take place before the registrant sees the patient.

Delegation of an authorized act must only take place when the registrant is present in the same clinical location as the patient and is available to intervene if required. The registrant directly supervises the delegated procedure.

Registrants must establish a process for delegation that includes:

- education and assessment, ensuring the currency of the delegate's knowledge, skills and judgement
- documentation/references for performance of procedures
- ensuring the delegate has been delegated only those acts that form part of the registrant's regular practice
- an ongoing quality assurance mechanism

Delegation occurs with the informed consent of the patient. Whether the consent is implicit or explicit depends on the particular activity being delegated.

E.4.2. Assignment

Assignment of certain procedures that are not controlled acts may occur as part of the optometric examination and may occur prior to the registrant assessing the patient.

Procedures that are completely objective, present no inherent risk of harm and require no interpretation by the person performing the procedure may be performed without the presence of the registrant and are considered to be remotely supervised. This may include automated procedures such as objective auto-refraction, auto-perimetry and non-mydriatic retinal photography. The registrant is expected to review the results of these remotely supervised procedures and communicate appropriately with the patient. Direct supervision must occur whenever the procedure poses an immediate (e.g., tonometry) or potential (e.g., subjective refraction) risk of harm.

As with delegation, it is expected that assignment will only occur with certain processes in place, including:

- education and assessment ensuring the currency of the assignee's knowledge, skills and judgement
- documentation/references for performance of procedures
- ensuring assignment of only those procedures that form part of the registrant's regular practice

E.4.3. University Research

An exception exists for delegation and assignment where medical direction is delegated with indirect supervision, with the informed consent of the subject, and where the research has received research ethics board approval from an accredited university.

E.4.4. Receiving Delegation of Controlled Acts

In the public interest, there are situations when a registrant could receive delegation from another regulated health professional to perform a controlled act not authorized to optometry. Other

regulated health professionals have delegation regulations and established protocols for delegation of which the registrant should be aware.

In order for a registrant to receive delegation from another regulated health professional, all of the following criteria must be met:

- a process for receiving delegation is in place
- the registrant has a reasonable belief that the regulated health professional delegating the act is authorized to do so, has the ability to perform the act competently, and is delegating in accordance with relevant regulations governing their profession
- the registrant is competent to perform the act safely, effectively and ethically
- appropriate resources, such as equipment and supplies, are available and serviceable
- the delegated act is clearly defined
- the duration of the delegation is clearly defined and relates to a specific patient
- the registrant ensures that patient consent to having the act performed under delegation to the registrant is obtained and recorded in the patient's health record
- a mechanism exists to contact the regulated health professional who delegated the act if there is an adverse or unexpected outcome
- the identity of the regulated health professional delegating the controlled act and of the registrant are added to the patient record

E.5. DISPENSING

Registrants are authorized to dispense spectacles and contact lenses to patients who have a valid prescription. Patients may choose to have their prescription filled by the prescriber or by another dispenser.

All dispensing services provided online must meet the same professional standards as those provided in person.

Patients have the right to decline in-person fitting and adjustment of spectacles. Registrants must use their professional judgement in determining whether to agree to a patient's request for delivery of prescription eye glasses prior to in-person fitting.

The last regulated professional to provide eye-related care to the patient is considered the most responsible dispenser.

E.6. REFERRALS

A referral is a request to another regulated health professional for consultation and/or the provision of treatment when a patient requires care that exceeds the registrant's scope of practice or ability. Timeliness of the referral is influenced by the ocular and/or systemic conditions and risk factors of patients.

Once the decision has been made to make a referral, appropriate documentation in the patient's health record is necessary, including:

- confirmation of when the referral was requested
- appointment date, time and consultant
- confirmation with the patient of the appointment time and location
- a copy of the pertinent clinical information forwarded to the consultant

Registrants may need to advise patients on seeking an alternative source of care, such as a hospital emergency department, if a referral appointment is not available within an appropriate amount of time for their condition, or if their condition worsens.

E.7. SHARED CARE

Registrants must refer patients to an appropriate regulated health professional when the patient's condition and/or treatment is beyond the scope of their own practice. This usually results in referral to family physicians or ophthalmologists to institute medical and/or surgical care.

E.7.1. Referrals to Physicians

When making a referral to a physician, registrants shall ensure the patient fully understands:

- their diagnosis
- the options for care
- why they are being referred
- the roles and responsibilities of the professionals involved and any associated fees

E.7.2. Referrals to Optometrists

A registrant may refer a patient to another optometrist for specific assessment and treatment (e.g., dry eye therapy, binocular vision therapy, myopia management, imaging, visual fields).

The primary optometrist must communicate to the patient what their role will be during the referral process and the protocol for follow up. The requisition to the second optometrist must include pertinent clinical information.

The second optometrist must:

- communicate to the patient the nature of their role, including the anticipated duration of care
- ensure an up-to-date, comprehensive oculovisual assessment has been conducted
- maintain a patient health record, including the requisition information and results

Any new symptoms or concerns should be returned to the primary optometrist, who is responsible for the components of a comprehensive eye examination.

F. APPENDIX: SPECIFIC DISEASES, DISORDERS & PROCEDURES

F.1. REFRACTIVE ERRORS

F.1.1. Spectacle Therapy

Registrants are authorized to dispense spectacles. The provision of spectacle therapy involves:

- reviewing with the patient any relevant environmental, occupational, educational, avocational and/or physical factors affecting spectacle wear
- reviewing and confirming details and validity of prescriptions
- advising the patient regarding appropriate ophthalmic materials and lens design
- taking appropriate measurements (e.g., interpupillary distance and segment height) to ensure proper function of the spectacles
- confirming the suitability of the order and arranging for the fabrication of the spectacles
- verifying the accuracy of the completed spectacles to ensure they meet required tolerances
- fitting or adjusting the spectacles to the patient
- counselling the patient on aspects of spectacle wear including expectations, limitations, customary adaptation period and maintenance requirements of the spectacles

F.1.2. Contact Lens Therapy

Registrants are authorized to prescribe and dispense contact lenses for the treatment of:

- disorders of refraction, and/or sensory and oculomotor dysfunctions of the eye and vision system
- diseases/disorders affecting ocular health
- anatomical, structural and/or cosmetic concerns

The provision of this service to patients involves:

- an initial assessment to determine their suitability for contact lens therapy
- a determination of the parameters of a contact lens appropriate for patients
- ongoing monitoring of the efficacy of treatment

Contact lenses are classified by Health Canada as a medical device, not a consumer commodity, and must be treated accordingly.

F.1.2.1. Initial Contact Lens Fitting

Before contact lens fittings, registrants obtain required clinical information to determine the suitability of patients for contact lens wear, with special emphasis on:

- the health of the cornea, conjunctiva, lids, tarsal and bulbar conjunctiva, and the integrity of the tear film
- corneal curvature
- refractive status and visual acuity
- the effects that contact lens wear may have on the function of the accommodative, oculo-motor and sensory systems
- relevant environmental, occupational, avocational and systemic health factors affecting contact lens wear

Patients must be instructed with respect to:

- hygiene
- lens insertion and removal
- use of specific lens care products
- recommended wearing times and replacement schedules
- normal and abnormal adaptive symptoms
- contraindications to lens use
- progress evaluations
- appropriate instructions on how and when to access emergency care

Patients are examined during the adaptation period to assess lens performance, adaptation and compliance.

Once registrants are satisfied that the adaptation process is complete, and that the parameters of the contact lenses are correct, a contact lens prescription can be finalized. Registrants are entitled to remuneration for all professional services involved in the determination of these prescriptions.

F.1.2.2. Continuing Care

Registrants provide continuing care to established contact lens patients, including:

- maintaining a history concerning:
  - the specifications, age and wearing schedule of current contact lenses
  - the current lens care regimen

  - any adverse reactions associated with contact lens wear
- assessing patients to determine if they are achieving acceptable outcomes of contact lens wear

F.1.3. Myopia Management

Myopia management involves the use of certain interventions as options for vision correction or to slow the progression of myopia in children. It should be strongly considered for all emerging myopes.

Axial length measurements should be considered as a way of monitoring treatment efficacy over time.

Management of myopia must include patient education regarding proper visual hygiene and environmental risk factors and may include:

- specialty contact lenses that alter the corneal shape, including orthokeratology (Ortho-K)
- specialty contact lenses, including soft lenses
- specialty spectacle lenses
- pharmaceutical treatment

F.1.4. Low Vision Assessment

A low vision examination generally will include:

- a comprehensive patient history that explores:
  - personal social history, including patient-identified impact of visual impairment, such as specific limitations in activities of daily living and goals (vocational/educational/avocational requirements)
  - personal perspective regarding stability of vision
  - current access to services
  - current devices and usage/satisfaction
- results of the patient's most recent optometric examination, and re-assessment, as necessary

F.2. BINOCULAR VISION DYSFUNCTION & VISUAL REHABILITATION

When the initial assessment and binocular vision testing identifies areas of concern, management of binocular vision disorders includes:

- refractive and prismatic corrections
- full or partial occlusion
- amblyopia therapy
- vision therapy (including the management of visual symptoms related to learning disorders, concussion and traumatic brain injury)

- consultations with other healthcare professionals

F.2.1. Amblyopia

Amblyopia is a diagnosis of exclusion. Diagnostic evaluation of new patients with suspected amblyopia includes:

- prenatal and perinatal case history
- reading level and performance in school
- impact on visual function and activities of daily living

F.2.2. Vision Therapy

Registrants do not diagnose learning disorders, concussion or TBI. They do play a role in investigating and managing visual signs and symptoms that may be associated with these diagnoses.

Assessment of such patients must include:

- case-specific history
- impact on visual function and activities of daily living

F.3. PRESCRIBED DISEASES

F.3.1. Dry Eye Disease

When providing care to patients with dry eye disease (DED), registrants will begin with a specific case history, with special attention to risk factors including:

- relevant health conditions (e.g., connective tissue and autoimmune disease)
- topical and systemic medications (e.g., antihistamines, antidepressants, diuretics and preservatives accompanying topical medications)
- environmental and occupational factors

Treatment of DED aims to restore homeostasis of the tear film and ocular surface and address patient symptoms.

F.3.2. Uveitis

Beyond the initial assessment requirement, registrants must include:

- case-specific history and review of systems
- dilated fundus exam
- macular imaging when indicated

Treatment options include:

- addressing inflammation and pain
- monitoring intraocular pressure, including control thereof if needed

- recommending referral when appropriate, including initiating communication with the patient's primary care physician or another health care provider when systemic conditions are suspected

F.3.3. Age-Related Macular Degeneration

The evaluation of patients suspected of having age-related macular degeneration (AMD) includes:

- case history with attention to specific risk factors for or symptoms of AMD
- ocular examination, including:
  - additional assessment of macular function and structure (e.g., Amsler grid and OCT if indicated)
  - posterior segment examination with pupillary dilation

The management of patients with AMD includes:

- patient education regarding
  - potential benefits of supplements, where clinically indicated
  - benefits of smoking cessation or other lifestyle changes
  - home monitoring with monocular Amsler grid or equivalent
- making a timely referral for patients with progression of neovascular disease

F.3.4. Glaucoma

The core considerations for the diagnosis and management of patients with glaucoma or a high suspicion of developing glaucoma include:

- case history with attention to specific risk factors for glaucoma
- measurement of intraocular pressure
- evaluation and description of the optic nerve head through dilated pupils
- quantitative assessment of the angle
- investigation of threshold visual fields*
- measurement of central corneal thickness, when clinically indicated
- imaging of the optic nerve head and retinal nerve fiber layer*

* These tests may not be required if the patient's signs and/or symptoms indicate a referral to a secondary or tertiary eye care provider for the continuing diagnosis and/or management of glaucoma.

Registrants are only authorized to treat primary open angle glaucoma (POAG). All other subtypes of glaucoma must be referred

to an ophthalmologist. Patients with POAG must be referred to an ophthalmologist if the treatment is complicated by a concurrent medical condition or a potentially interacting pharmacological treatment.

F.4. HEALTH CONDITIONS WITH OCULAR RISK

All patients with systemic disease with high risk of retinal/vascular complications (e.g., diabetes, hypertension) require periodic assessment of the eye and vision system. For such patients:

- Dilation is indicated
- OCT/imaging is highly recommended

Patients must be advised as to the appropriate frequency of such assessments, depending on factors such as the duration of the disease, the nature of the condition and the clinical findings.

Any abnormalities found are documented and the patient's primary health care provider is advised as necessary of any findings that may pose a threat to the patient's ocular or systemic health.