Sample Encounter Note: Allergic Conjunctivitis

Ancillary tests:

Required: None

Optional:

- Conjunctival scrapings for cytology
- Indication: Confirm allergic component (eosinophilia)

- Skin testing
- Indication: Confirm allergic component

- Serum IgE
- Indication: Confirm allergic component

As allergic (seasonal or perennial) conjunctivitis is a clinical diagnosis requiring no additional confirmatory tests beyond the comprehensive exam data provided, the candidate would receive full credit if no additional tests were ordered.

The candidate would not have points deducted had they elected to order any appropriate optional testing (with justification).

The candidate is **not required** to request any optional tests if none are indicated.

Diagnosis: Conjunctivitis, Allergic

A single *diagnosis* from the dropdown menu elastic search field is **REQUIRED.**

Location: OU.

A correct location is **REQUIRED.**

Plan:

- **Therapeutics:**
  - Olopatadine ophthalmic sol. 0.2%. 1 gtt OU qd
    [Several pharmaceutical alternatives may be correct]
  - Preservative-free artificial tears qid OU.
  - Cool compresses several times per day.
  - Environmental control of allergens (e.g., HEPA air filtration, dehumidifiers).

- **RTC:** 1 – 2 weeks

- **Patient Education:**
  - **Diagnosis**
    - Patient was informed they have an inflammation of the eyes termed Allergic conjunctivitis OU.
  - **Etiology/Pathophysiology**
    - Patient was informed that allergic conjunctivitis is usually due to seasonal or perennial allergens (e.g., pollens or molds).

The plan consists of three **REQUIRED** elements to be documented:

1. **Therapeutics** (pharmacologic or non-pharmacologic prescriptions), MUST be written out completely. Referrals to other practitioners or services, e.g., vision therapy (along with reasons for referrals, e.g., TBI) should also be included here.
2. **Return-To-Clinic (RTC)** should be written as a range (days, weeks, months) within which the patient is to follow up with the provider (the candidate).
3. **Patient Education** that itself consist of two sub elements (instructions) that need to be documented:
   1) **Diagnosis** given to the patient.
   2) **Etiology/Pathophysiology** explained to the patient.

NOTE: The plan should be written as a outlined summary, as one would document in an EHR. It should not be a long verbatim transcript of the conversation with the standardized patient.

NOTE: In addition to the written documentation above, the diagnosis, etiology, and treatment needs to be verbally communicated to the standardized patient in patient-centered language.

Sample Encounter Note: Asteroid hyalosis

Ancillary tests:

Required: None

As asteroid hyalosis is a clinical diagnosis requiring no additional confirmatory tests beyond the comprehensive exam data provided, the candidate would receive full credit if no additional tests were ordered.

The candidate would not have points deducted had they elected to order any appropriate optional testing (with justification).

The candidate is **not required** to request any optional tests if none are indicated.

Optional testing:

- Macular OCT
- Indication: to evaluate macular integrity.

- B-scan ultrasonography
- Indication: to evaluate retinal integrity through dense asteroid hyalosis.

Diagnosis: Asteroid hyalosis

A single *diagnosis* from the dropdown menu elastic search field is **REQUIRED.**

Location: OS

A correct location is **REQUIRED.**

Plan:

- **Therapeutics:**
  - Reassurance. No therapy warranted.
  - Referral to PCP to follow-up on association with diabetes, hypertension, and hypercholesterolemia.
- **RTC:** 10 – 12 months
- **Patient Education:**
  - **Diagnosis**
    - Educated patient on asteroid hyalosis.
  - **Etiology/Pathophysiology**
    - The condition consists of multiple vitreous floaters made up of calcium and phosphate crystals. This condition is often associated with diabetes, hypertension, and hypercholesterolemia.

The plan consists of three **REQUIRED** elements to be documented:

1. **Therapeutics** (pharmacologic or non-pharmacologic prescriptions), MUST be written out completely. Referrals to other practitioners or services, e.g., vision therapy (along with reasons for referrals, e.g., TBI) should also be included here.
2. **Return-To-Clinic (RTC)** should be written as a range (days, weeks, months) within which the patient is to follow up with the provider (the candidate).
3. **Patient Education** itself consist of two sub elements (instructions) that need to be documented:
   1) **Diagnosis** given to the patient.
   2) **Etiology/Pathophysiology** explained to the patient.

NOTE: The plan should be written as a outlined summary, as one would document in an EHR. It should not be a long verbatim transcript of the conversation with the standardized patient.

NOTE: In addition to the written documentation above, the diagnosis, etiology, and treatment needs to be verbally communicated to the standardized patient in patient-centered language.

Sample Encounter Note: Compound Myopic Astigmatism

Ancillary tests:

Required: None

Optional testing: Manifest refraction and dry retinoscopy are given for all refractive cases. For any refractive case, additional testing may be ordered if indicated. Examples:

- Cycloplegic refraction
- Indication: to confirm or rule out latent hyperopia.

- Corneal topography
- Indication: to confirm or rule out irregular astigmatism.

As compound myopic astigmatism is a clinical diagnosis requiring no additional confirmatory tests beyond the comprehensive exam data provided, the candidate would receive full credit if no additional tests were ordered.

The candidate would not have points deducted had they elected to order any appropriate optional testing (with justification).

The candidate is **not required** to request any optional tests if none are indicated.

Diagnosis: Astigmatism, Compound Myopic

A single *diagnosis* from the dropdown menu elastic search field is **REQUIRED.**

Location: OU

A correct location is **REQUIRED.**

Plan:

- **Therapeutics:**
  - OD: -2.25 - 1.25 x 174
  - OS: -2.25 - 1.75 x 178
  - Trivex lenses
  - Full-time wear
- **RTC:** 10 – 12 months
- **Patient Education:**
  - **Diagnosis**
    - Educated patient on compound myopic astigmatism.
  - **Etiology/Pathophysiology**
    - The patient was informed they are both nearsighted and have a component of astigmatism, due to parts of the image coming to a focus in front of the retina at two different sites.

The plan consists of three **REQUIRED** elements to be documented:

1. **Therapeutics** (pharmacologic or non-pharmacologic prescriptions), MUST be written out completely. Referrals to other practitioners or services, e.g., vision therapy (along with reasons for referrals, e.g., TBI) should also be included here.
2. **Return-To-Clinic (RTC)** should be written as a range (days, weeks, months) within which the patient is to follow up with the provider (the candidate).
3. **Patient Education** that itself consist of two sub elements (instructions) that need to be documented:
   1) **Diagnosis** given to the patient.
   2) **Etiology/Pathophysiology** explained to the patient.

NOTE: The plan should be written as a outlined summary, as one would document in an EHR. It should not be a long verbatim transcript of the conversation with the standard patient.

NOTE: In addition to the written documentation above, the diagnosis, etiology, and treatment needs to be verbally communicated to the standardized patient in patient-centered language.