# EYE CARE
# SERVICE AUDIT WORKSHEET

| | |
|---|---|
| Patient ID: | Patient: |
| Date of Service: | Physician: |

| | HISTORY OF PRESENT ILLNESS | | EXAM |
|---|---|---|---|
| | Location (OD, OS, OU) | | Visual Acuity |
| | Quality (Glare, burn, itch, watering) | | Pupils (including shape) |
| | Severity (Intense, sharp, mild, moderate) | | Extraocular Movements |
| | Duration (Minutes, hours, days, weeks) | | Confrontation Fields |
| | Timing (AM, PM, Constantly) | | Intraocular pressure |
| | Context (While driving, looking up) | | Adnexa |
| | Modifying Factors (light, work, meds) | | Conjunctiva |
| | Associate Signs & Symptoms (swelling, nausea) | | Cornea |
| | *Circle Y or N for each below* | | Anterior Chamber |
| Y or N | Chief Complaint Documented | | Lens |
| Y or N | Complete Review of Systems | | Optic disc (including size) |
| Y or N | Complete Family History | | Posterior Segment |
| Y or N | Complete Social History | | Psych & Neuro |

| | Problem-Focused | Expanded Problem-Focused | Detailed | Comprehensive |
|---|---|---|---|---|
| **History** | | | | |
| HPI | 1-3 | 1-3 | 4+ | 4+ |
| Review of Systems | 0 | 1 | 2-9 | 10+ |
| PFSH | 0 | 0 | 1 | 2-3 |
| **Exam** | 2+ | 6+ | 9+ | 12 |

| | Straightforward | Low Complexity | Moderate Complexity | High Complexity |
|---|---|---|---|---|
| **Problem Severity** | 1 | 2 | 3 | 4 |
| **Medical Decision Making** | | | | |
| Diagnosis | 1 | 2 | 3 | 4+ |
| Test | 1 | 2 | 3 | 4+ |

Level Billed: _____ Level Documented: _____ All Services Performed Billed: Y or N Recall or Return Appointment made: Y or N

Notes: _____

_____

Chart audited on: _____ by: _____