CALIFORNIA STATE BOARD OF OPTOMETRY

**STATE BOARD OF OPTOMETRY**
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# Documentation of Co-Management of Glaucoma Patients for Preceptorship Program

Authority: Business and Professions Code § (BPC) 3041(f) and
California Code of Regulations (CCR) §1571 (a)(4)(C)

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|---|---|---|
| **Name of Optometrist: (Please Print)** | **License #:** | |
| **Principal Place of Practice Address:** | **Phone #:** | |
| **City:** | **State:** | **Zip:** |
| **Name of "Preceptor": (Please Print)** | **Optometric/Medical License #:** | |

**When Did You Begin the Preceptorship/Co-management of Patients:**

☐ **Pursuant to SB 929 (Stats. 2000, ch. 676, § 3) from 1/1/2001 to 12/31/2009**
(50 patients for 2 years)

**How many patients are you applying from the SB 929 process towards the Case Management Requirement, if any? _____**

☐ **Pursuant to CCR § 1571, on or after January 8, 2011**
(25 patients for 12 consecutive months)

**Instructions**: In order to receive a glaucoma certification, California licensed optometrists must demonstrate that they have initially evaluated and co-managed with a preceptor 25 primary open-angle glaucoma patients who are over 18 years old for a minimum period of 12 consecutive months. This form is used to document evidence that the California licensed optometrist and board certified ophthalmologist or glaucoma certified optometrist listed above have completed co-management of the glaucoma patients listed below as required in Business and Professions Code Section 3041(f). One form should be filed for each collaborating board certified ophthalmologist or glaucoma certified optometrist.

Licensees who started the process for certification to treat glaucoma under SB 929 (Stats. 2000, ch. 676, § 3) and did not complete the requirements by December 31, 2009, may apply all patients who have been co-managed prospectively for at least 12 consecutive months towards the Case Management Requirement indicated in subsection (a) of CCR section 1571.

A "preceptor" for purposes of this program is defined as:

1) A California licensed, Board certified ophthalmologist in good standing; or

2) A California licensed optometrist in good standing, who has been glaucoma certified for two or more years (CCR § 1571 (a)(4)(c)).

For the purposes of the preceptorship program "treat" is defined as:

> Properly evaluating the patient, performing all necessary tests, diagnosing the patient, recognizing the type of glaucoma within a licensee's scope of practice, creating a treatment plan with proposed medications and target pressures, ongoing monitoring and re-evaluation of the patient's condition, and making timely referrals to an ophthalmologist when appropriate (CCR § 1571 (a)(4)).

"Preceptors" must confirm the diagnosis and treatment plan, and then approve the therapeutic goals and management plan for each patient. Consultation with the "preceptor" must occur at appropriate intervals or when the therapeutic goals are not achieved. Clinical data will be exchanged at appropriate intervals determined by the "preceptor" and the licensee. Telemedicine and electronic exchange of information may be used as agreed upon by the "preceptor" and the licensee. Each patient that is seen by the optometrist in the program will count as a 1-patient credit towards the Case Management Requirement.

**Note:** Optometrists wishing to obtain glaucoma certification must attach this form to an "Application for Glaucoma Certification" provided by the State Board of Optometry.

One of the "PATIENT" boxes on the next page must be fully completed for each patient.

**PLEASE COPY, PRINT, AND USE THIS PAGE FOR EACH PATIENT TREATED (1-25 PATIENTS).**

***PLEASE WRITE LEGIBLY OR YOUR DOCUMENTATION FORM MAY BE RETURNED TO YOU FOR CLARIFICATION.***

| **PATIENT # _____** | |
|---|---|
| **Patient First Name and Last Initial (i.e., John D.):** | |
| **Month, Date and Year of Initial Evaluation of Patient with Preceptor:** | |
| **Month, Date and Year Diagnosis Confirmed & Treatment Plan Approved:** | |
| **Month, Date and Year Therapeutic Goals and Management Plan Approved:** | |
| **Follow-up Consultation Dates with Patient. List appropriate clinical intervals as determined by the preceptor and licensee (<u>you must indicate the month, day, and year</u>):** | |
| **Therapeutic Goals Achieved?**<br>☐ Yes<br>☐ No<br>(If therapeutic goals were not achieved, list date(s) of consultation with preceptor and note action taken i.e., referral to ophthalmologist, development of new plan.) | |
| **Patient was treated for a minimum of 12 consecutive months?**<br>☐ Yes ☐ No | |
| **Additional Notes/Comments:** | |
| **Optometrist Signature:** | **Date:** |
| **Preceptor Signature:** | **Date:** |