



Itinerary Today

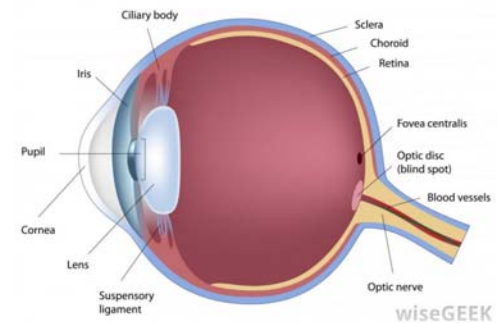
- Anatomy
- Physiology
- Exam
- WKC 16
- Cases
- Questions

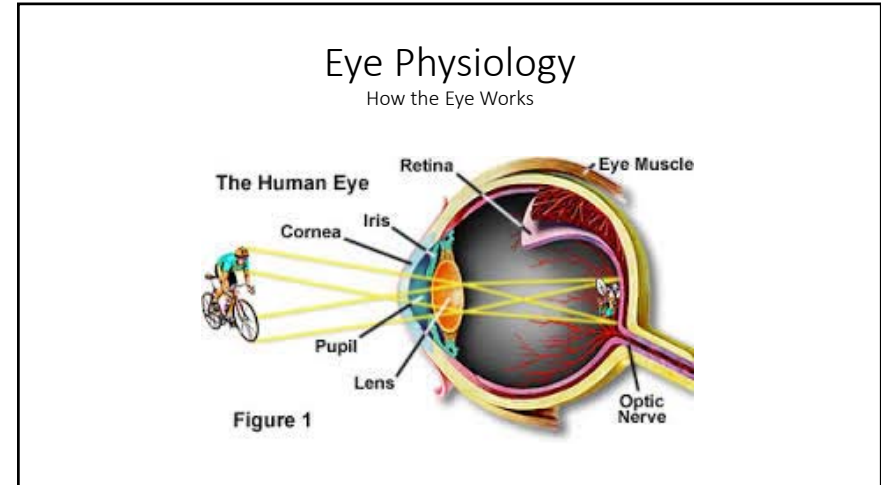
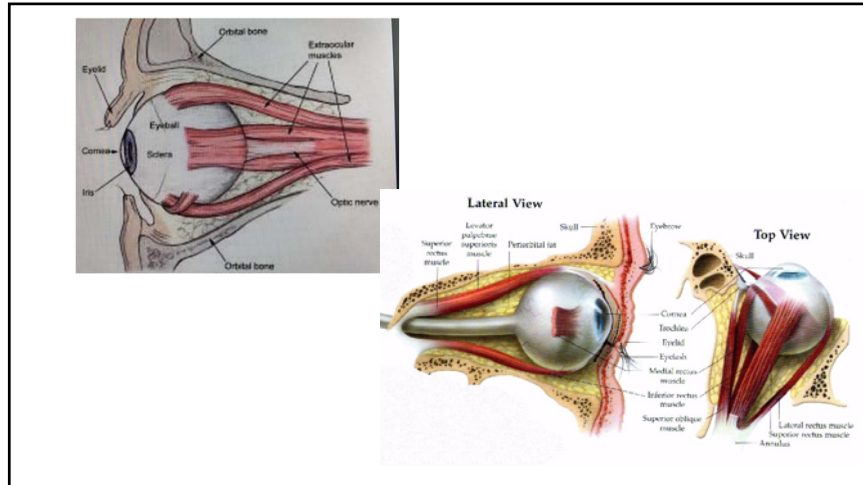
Hook Your Attention



Eye Anatomy

The Parts of the Eye
Human Eye Anatomy





History

- Review Workplace Incident
- Present Symptoms – blurry, pain, glare, etc
- Effect on Life/Work – driving, computer, reading, etc
- Previous Trauma
- Previous Eye Surgery
- Near-Sighted/Far-Sighted
- Presbyopia

Eye Exam

What are we looking for?

- OD = Right Eye
- OS = Left Eye

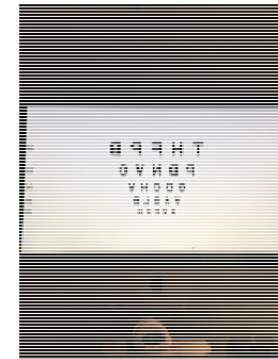


Measuring Visual Acuity

- 20/20
- 20/40
- 20/200
- 20/15

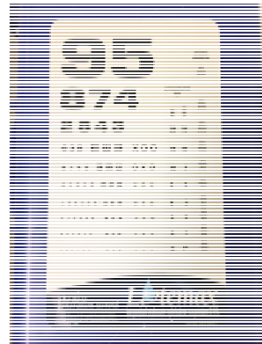
Measuring Visual Acuity

- Distance Vision
 - Without correction = VA sc
 - With correction = VA cc
 - Best corrected = VA cc



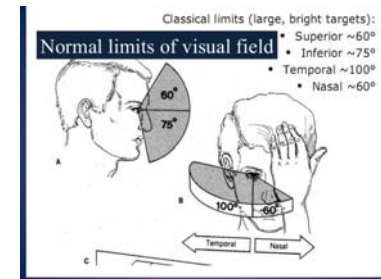
Measuring Visual Acuity

- Near Vision
 - Without correction = VA sc
 - With correction = VA cc
 - Best corrected = VA cc



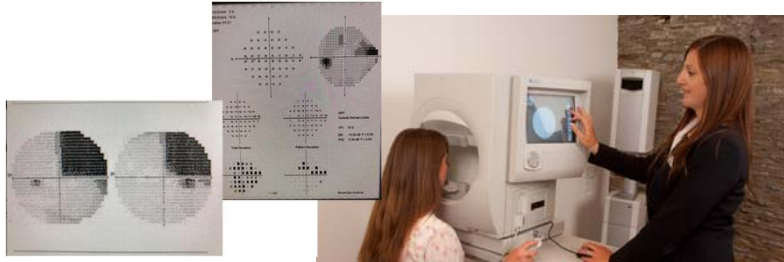
Measuring Visual Fields

- By Confrontation – “full to confrontation”



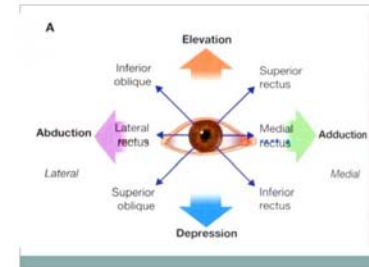
Measuring Visual Fields

- By Automated Perimeter



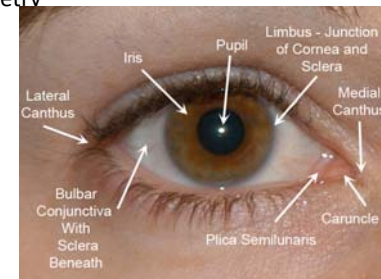
Extraocular Movements

- Up/Down/Left/Right – Full
- Straight – Ortho
- Strabismus – Double vision
- Diplopia - ?monocular



External Exam

- Eyelids – position, symmetry
- Orbit



Ectropion



Pupil Exam

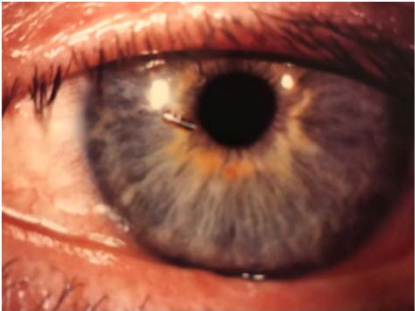
- Equal
- Round
- Reacts to light
- Reacts to accommodation

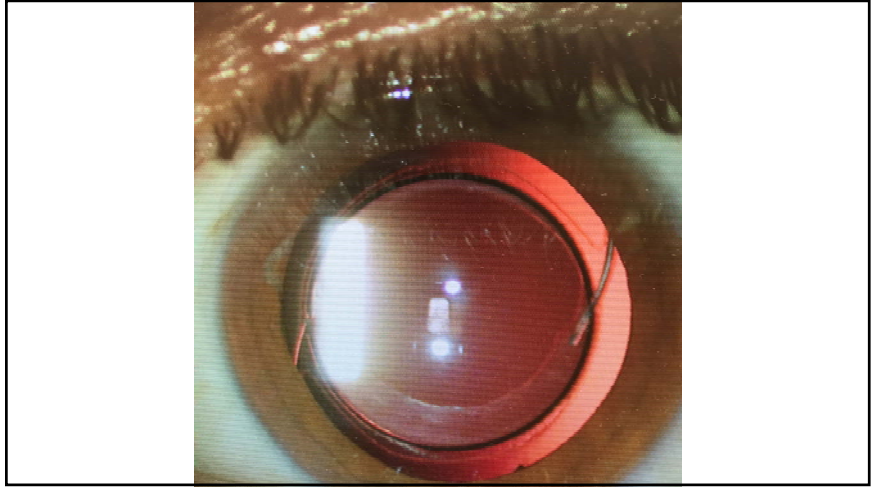
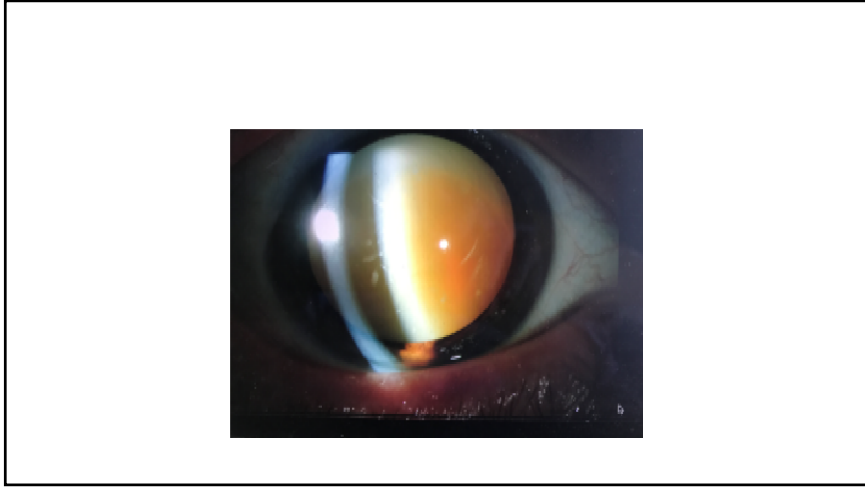
“PERRLA”



Slit Lamp Exam


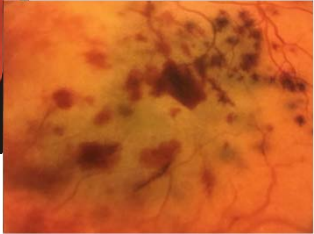
- Lids
- Conjunctiva
- Cornea
- Anterior Chamber
- Lens





Vitreous and Retina Exam

- Floaters
- Macula
- Optic Nerve
- Retina Vessels
- Retina Periphery

WKC 16 Form

Let's fill one out together!

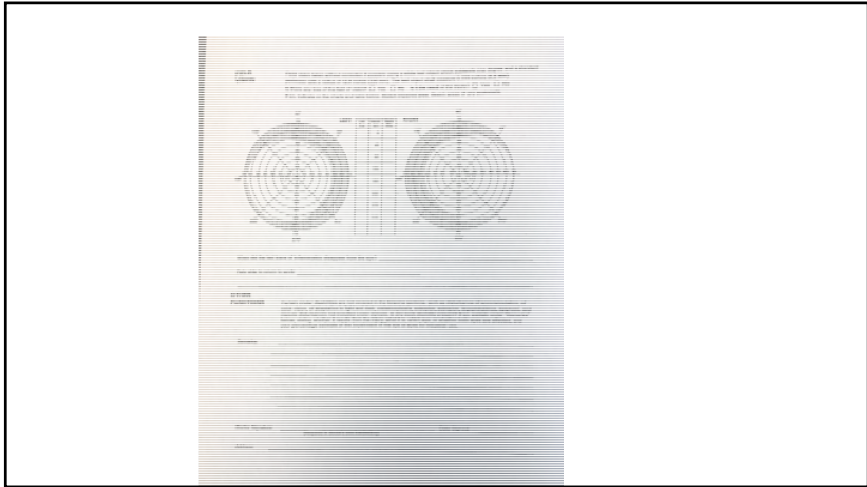
Department of Workforce Development
Division of Compensation Services
100 North Dearborn Street, 10th Floor
Chicago, IL 60610
www.wkcd.com
800-333-3333

PHYSICIAN'S REPORT ON EYE INJURIES
Public Use - Ref. 80-20, Lines of vision, determination

The completion of your report requires a physician's signature. Failure to provide a signature may result in a determination pending further review. Information on penalty rules can be found in the Illinois Workers' Compensation Act, 805 ILCS 230/1-2.

PATIENT		Employee Name		Employee Employer Name	
Social Security Number		Employee Address		Employee Telephone Number	
HISTORY		Employee Dates		Employee Injury Dates	
Date of First Treatment		Date of Last Treatment or Exam		Date of Last Exam	
If only one eye is injured, is the other eye affected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, if any, specify:					
NATURE OF INJURY AND CAUSATION					
Please list the details of the injury or condition.					
<input type="checkbox"/> The patient was injured by a fall of object or part of object <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly <input type="checkbox"/> The patient was injured by a fall of person or part of person <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly <input type="checkbox"/> The patient was injured by a fall of vehicle or part of vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly <input type="checkbox"/> The patient was injured by a fall of object or part of object <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly <input type="checkbox"/> The patient was injured by a fall of person or part of person <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly <input type="checkbox"/> The patient was injured by a fall of vehicle or part of vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly <input type="checkbox"/> The patient was injured by a fall of object or part of object <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly <input type="checkbox"/> The patient was injured by a fall of person or part of person <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly <input type="checkbox"/> The patient was injured by a fall of vehicle or part of vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partly					
CENTRAL VISUAL RESPONSE					
Central Visual Response: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify) <input type="checkbox"/> Unknowable If abnormal, specify: _____ If unknowable, specify: _____ Use ASA Reading Card up to 10/500.					
IMPORTANCE					
Injury: <input type="checkbox"/> Minor <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Critical If critical, specify: _____ If moderate, specify: _____ If minor, specify: _____ If unclassifiable, specify: _____ Use ASA Reading Card up to 10/500.					
PLEASE FILL OUT EACH LINE COMPLETELY FOR EACH EYE					
Right	Visual Acuity	Visual Field	Visual Acuity	Visual Field	Visual Acuity
	Normal	Normal	Normal	Normal	Normal
Left	Visual Acuity	Visual Field	Visual Acuity	Visual Field	Visual Acuity
	Normal	Normal	Normal	Normal	Normal
PROXIMAL					
Did the employee wear glasses or contact lenses at the time of the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Factors: In the preceding paragraph, did the employee wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Factors: Is there a record or positive indication of pre-existing ocular disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Factors: Is there a record or positive indication of pre-existing ocular disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Factors:					
BINOCCULAR VISION					
Is there a record or positive indication of pre-existing ocular disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Factors: Is there any diplopia present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Factors: If yes, the diplopia is present in the right or the left or both eyes or in each eye as which appears to favor. The test is to be made with any reasonably useful corrective lenses. Was each correction used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Factors:					

WKC 16-16 (01/17)



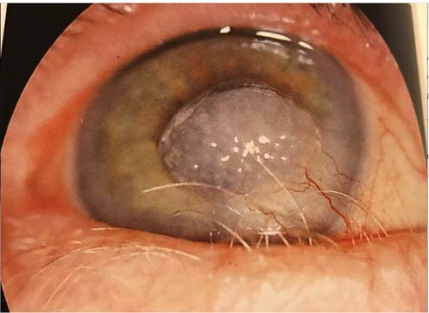
Case #1

- 55 y/o Plumber
- Chemical splash to eye



Case #2

- 47 y/o Automobile mechanic
- Chemical splash to eye





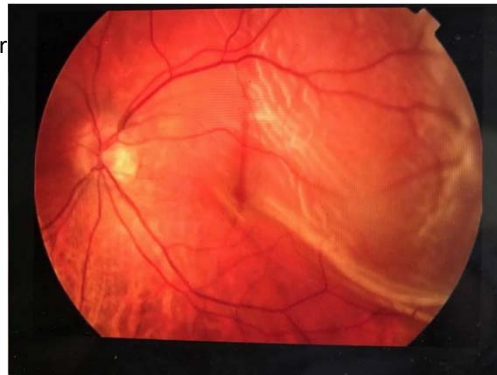
Case #3

- 28 y/o Factory worker
- Hammering
 - claimed to be wearing safety glasses



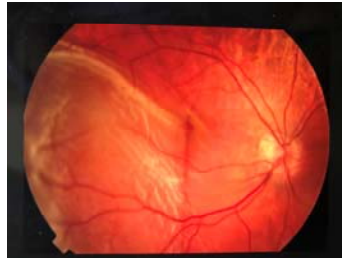
Case #4

- 61 y/o grocery store worker
- Lifting crate of oranges
- Flashes/floaters that day
- Retinal Detachment



Case #5

- 59 y/o factory worker
- Lifting steel beams
- 2 weeks later – flashes/floaters
 - retinal detachment
- Hx
 - very near-sighted
 - cataract surgery



Case #6

- 33 y/o truck driver
- Unloading cargo – knocked unconscious
- Traumatic Brain Injury – TBI
- Light sensitive
- Trouble reading
 - convergence insufficiency

Case #7

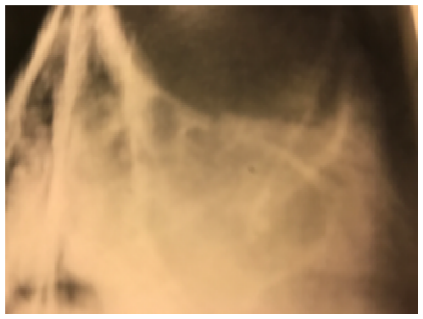
- 52 y/o taxi driver
- MVA – airbag deployed
- Double vision – diplopia
- Blow out fracture



Airbag to Eye

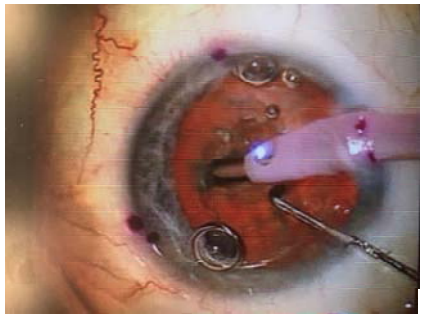
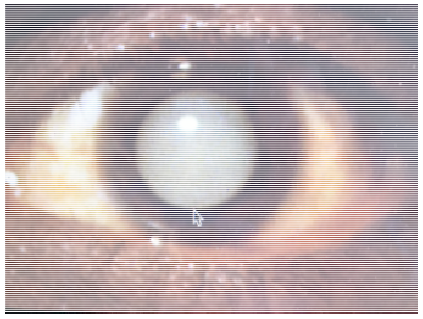


Blow out fracture



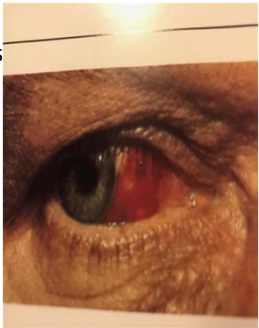
Case #8

- 41 y/o factory worker
- Walking into beam
- Hyphema
- 6 months later – developed cataract

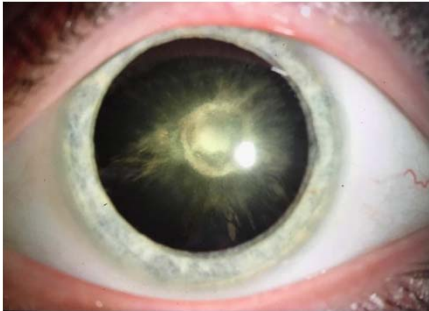


Case #9

- 21 Y/O Construction worker
- Grinding without safety glasses



Intraocular Foreign Body



Non-Organic (Functional)

- Malingering
- Hysteria

