

# OneSight IT Operations

Recall Consent

Admin

User Guide



**ONESIGHT**

EssilorLuxottica Foundation

## Overview

This document details the steps required to recall a patient consent form. This process should only be done by clinic managers or those given the task to do so.

## Access

To access the Recall Consent page please navigate to [www.onesightclinics.org](http://www.onesightclinics.org). At the top of the page click on the option for “Admin”. It will be under the “More” section as seen below:




On the admin page you will select the option for “Recall Consent” as seen below.



**Retrieve a Copy of a Completed  
Digital Consent Form.**

You will now see the admin login page. You will only be able to login here using admin credentials. Please enter in your admin username and password and click on “Login”

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**ADMIN LOGIN REQUIRED**      *Version 6.0*

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**User Name:**

**Password:**

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You are attempting to access an area of the system  
that is for **AUTHORIZED USERS** only. You must have an  
**ADMIN LEVEL** Login to proceed.

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**LOGIN**

Next, you will be on the “View Completed Consents” page. Here you will be able to search for a patient by the following fields.

**Clinic Name** – Select the clinic the patient is on from the drop down.

**Group** – Select the school, group, or community the patient was a part of.

**Record Number** – Type in the record number of the patient.

**First Name** – Type in the first name of the patient.

**Last Name** – Type in the last name of the patient.

**Birthday** – Type in or select the date of birth for the patient.

After you have filled in the patient information you can click the blue button at the bottom labelled “Search.”



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View Completed Consents

*Version 6.0*

This application will only retrieve forms completed through the online consent portal.  
If the registration was completed using another process, no form exists digitally and cannot be recalled.

<b>Clinic Name</b>	<input type="text"/>
<b>Group</b>	<input type="text" value="ANY"/>
<b>RECORD NUMBER</b>	<input type="text"/>
<b>First Name:</b>	<input type="text"/>
<b>Last Name:</b>	<input type="text"/>
<b>Birthday</b>	<input type="text"/> 
<b>Partner Consent</b>	<input type="text" value="Select"/>

SEARCH

## **Patient Consent Form**

The patient's consent form should now display. You will not be able to update or change anything on this page. This is simply used to pull up all information that was given during registration and print the form.

To print the consent form you will hit "ctrl + P" on the keyboard if you are using a Windows computer or "command + P" on the keyboard if you are using Apple. This will bring up the options for you to print to your desired printer.

Below is an example of what the form will look like.

### OneSight Patient Registration and Consent.

**Please read and complete the entire form.**

**Event Details**

Clinic Name	Group Name	APPOINTMENT DAY	Clinic ID Number
2019-US-OH-Kent	TEst	09/03/2019	255522

**Patient Information:**

First Name:	Last Name:	Birthday	Age	Grade
123456	12345r	9/4/2019		2nd

**Based on the patient's vision screening results, he or she is being referred to receive a free eye exam and glasses (if needed) at the OneSight Vision Clinic.** The free vision services will be provided in conjunction with OneSight, a leading vision care nonprofit, which provides a comprehensive eye exam and stylish glasses (if needed).

Note that when participating in a OneSight Vision Clinic, the patient will be at the vision clinic for approximately 3-5 hours. Please make arrangements to have any necessary medications and/or food available on the assigned clinic day. Patients will be supervised at all times by staff and will receive a copy of their vision exam results.

If you have any questions about the information provided in this Consent Form, please contact your school administrator or local point person.

**Consent to Provide Care:**

**Parent/Guardian/Patient MUST Complete All Sections of This Form and Sign Below for Participation in the OneSight Vision Clinic**

I give my permission for my child or if I am over 18, myself to receive a free eye exam and glasses, if needed, at the OneSight Vision Clinic.

**I. Waiver of Dilated Fundus Exam**

The state board of optometry may require a dilated fundus exam as part of an eye examination performed by a licensed optometrist. A dilated fundus exam is a thorough exam of the peripheral retina aided by the use of topical dilating eye drops. This procedure is used to diagnose abnormalities of the retina such as detachments, tears, tumors, infections, hemorrhages and genetic abnormalities. The dilating drops will leave the pupils dilated for approximately four hours. During this period the

patient may experience blurry vision and light sensitivity, which may make reading difficult.

**Dilate Consent?** <<--- **SELECTION REQUIRED**

Yes

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***Permission to Photograph:***

In the course of providing vision services at the OneSight Vision Clinic, OneSight may wish to take photographs of the patient, video and/or audio recordings of the patient, and/or statements the patient has made or written (the "Materials") for marketing or public relations purposes related to the OneSight Vision Clinic and its partners. I understand that by indicating my permission below, I waive the right to approve the finished copy of any electronic or printed Materials that are produced. I acknowledge that I am not entitled to compensation of any kind as a result of the use of the Materials. I further release OneSight from all liability that arises out of the use and disclosure of the Materials.

**Read the full Media Release Below:**

I hereby authorize OneSight and/or its representative(s), affiliate(s), and their agents ("OneSight"), to use, publish, display and reproduce photographs of me, video and/or audio recordings of me, and/or statements I have made or written (the "Materials") in connection with the vision services provided to me on (date/event above).

By signing this form, I authorize OneSight to disclose the Materials to the general public for

**Media Consent?** <<--- **SELECTION REQUIRED**

No

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**III. Confidentiality/Privacy and Impact Reporting**

**I understand that in order to provide vision services, OneSight will access my child's confidential health care records maintained by the School or District. I understand OneSight at all times maintains the confidentiality of the information it receives and agrees to never disclose my child's confidential information to any third party or government agency for any purpose without my consent or as otherwise required by law. I also understand that OneSight collects the vision screening and eye exam data of all children seen at the clinic. I understand that the data used by OneSight will not identify my child and that OneSight performs data analysis so it may share general impact reporting about improvements in students' vision after participating in the OneSight Vision Clinic.**

**IV. Release of Liability**

**In exchange for the free vision services provided to my child at the OneSight Vision Clinic,**

**Health History**

**Does the patient or anyone in their family have any history of Diabetes?**

Yes (Family)

**Does the patient or anyone in their family have any history of Glacoma?**

Yes (Patient)

**Does the patient or anyone in their family have any history of Hypertension?**

Yes (Patient)

**Does the patient or anyone in their family have any history of Macular Degeneration?**

**Does the patient or anyone in their family have any history of Cataracts?**

**Has the Student worn glasses before?**

Yes (Current)

**Pre Eye Exam Date**

9/17/2019

**Observations or Symptoms**

Crossed Eyes

**Please list any medications :**

123

**Please list any allergies:**

123

**Electronic Signature:**

Please sign your name in the box.



<b>Consent signed Timestamp</b>	<b>First Name Signer</b>	<b>Last Name Signer</b>	<b>Relationship</b>
09/16/2019 23:50:45	11	111	Guardian

<b>IP address</b>	<b>Date Signed</b>	<b>REG FORM USED</b>
76.189.130.221	09/09/2019	ESP FULL CONSENT

UPDATE