We can get a huge range of visual complaints from reasonable to mystifying. It is very rare that a patient comes into our office with an accurate self-diagnosis. Don't expect it to be that easy. We need to approach problem solving scientifically and skeptically while still building a trusting relationship with a potentially frustrated individual.

Usually your first encounter with a dissatisfied patient is at dispense. It is important to realize that they don't know what you know and that you have to educate them without being patronizing, judgmental, or too technical. We've all experienced the initial reaction of someone who puts their new glasses on and instantly tears them off demanding they aren't going to work. How YOU react to this or any range of dissatisfaction will greatly affect the success of the final outcome.

Always be on their side. Say things like, "I understand your frustration". Keep your comments positive and non-threatening to earn trust.

Even if you know exactly what is wrong, let your patient finish talking. If they put on their -3.00 cylinder glasses and one of their ears is an inch higher than the other, it's obvious to you that adjustments need to be made before they will have good vision. Wait until they are done venting about how this new prescription is so much worse and then politely say, "Can I borrow them, I would like to try something"

Many times what the patient has determined is the problem is incorrect, this is why observation is crucial. How many times has someone come in telling you to "tighten their nose pads" and then they look perplexed as you examine behind their ears at the temple bend. The same is true with prescription complaints. Mark up the progressives or optical center height and check alignment. Ask your patient to read, look at the computer and maybe walk around while you observe posture, height, head tilt, and eye movement. Then adjust for any lens tilt and alignment corrections followed by instruction on lens use and head movement.

Creating expectations should begin at the sale not at dispense. If you have a first time progressive wearer, first time glasses wearer, huge prescription change, digital lens upgrade, emerging cataracts, and so on, you need to discuss this change and possible adaptations and limitations when choosing the lens. It should be noted in the patient's record and then re-iterated at dispense. I will often discuss the benefits first such as "This new HD progressive lens will maximize the amount of space dedicated to computer and near vision. HOWEVER it is inherent with any progressive design that you need to scan the page with your nose as you won't get complete edge-to-edge clarity, but you will have wider zones overall". Or "With this new prescription you are going to get your best clarity possible. HOWEVER, due to your developing cataracts we can no longer get you seeing 20/20, but this is a huge improvement from how you were seeing out of your previous pair." Weighing in on compromises vs. benefits when it comes to different types of lens technologies as well. "You may have some peripheral soft focus in your new progressives but you gain a wider range of focal lengths and eliminate the line and image jump in your central vision as you had with your bifocal." or "We can make you an occupational computer progressive that

will increase the amount of intermediate and near vision in your glasses, but you will eliminate the far-distance correction." You don't want to blindside someone with the limitations of a particular lens, but you also don't need to focus on the negative.

Always sound like you know what you are talking about AND always actually know what you are talking about. If you are certified, hang your certificate right behind you and put those letters after your name on your card (prominently displayed) or on a name tag.

Never leave your patient hanging. You and I know there is an adaptation period to any changes in prescription or lens. After all, it is your brain that sees, not just your eyes. It is not ok to send a skeptical or unhappy patient packing with the instruction that they will get used to it. Have a system to follow-up with them in about a week. Write good notes about what you have talked about and say, "I would like you to try them for a week and I am going to call you to see if the changes we made today are working for you, but feel free to contact me with any other question or concerns."

What do you do when you get a phone call from someone who "can't see" out of their new glasses or demands to be seen by the doctor again because their prescription is wrong? If this call is taken by the reception desk, be sure there is a procedure in place for how to schedule these appointments and what verbiage needs to be used. We know many problems can be solved through adjustment and mistakes can be caught and remedied by the optician without wasting precious clinical time with the doctor. We don't want to tell anyone they can't see their doctor, but simply explain your comprehensive process for problem solving.

On that note, NEVER use the word "problem" at all. We tell patients that "We would like to schedule them for a "prescription evaluation" where we first have an optician re-verify your prescription, measurements, and proper adjustment to insure everything was made precisely as the doctor ordered. We also like to compare your new glasses with any previous pairs so if you could please bring them to this appointment. We will save a spot on the doctor's schedule should any re-evaluating be needed. This appointment will be at no cost to you." A note in the schedule regarding the chief complaint is all that is needed and the optician can take it from there. Now the optician can prepare for this appointment by reviewing the medical and prescription history as well as asking the examining doctor for any input or insight.

It is important to have a systematic process as well as a permanent record of your evaluation. A worksheet will ensure that you don't miss any pertinent details and it allows you to have consistency in your problem-solving and examine your findings easily. You must not only have a method in place but always review this with your patient before you begin in order to build trust in your routine. I normally start with, "First, let's review your concerns (listen and observe carefully with little or no input). Now, I am going to borrow your new and old pair of glasses and re-check that all of the specifications that we ordered and that the doctor has prescribed were made precisely and accurately. Then we will test how you are seeing out of them and ensure that it meets the expectations of the doctor's exam. We will get to the bottom of this and make it right, I promise."

Chief Complaint: Listen carefully and ask for lots of clarification regarding exact distances, head positions, activities, and situations where this is a concern.

Exam and Dispense Dates: Make sure the prescription that they filled was a recent one and that when they filled it was within the last few months. If they are due for a new exam or it is beyond a time frame where remaking the lens is no longer an option, make sure you and the patient have that information up front.

Rx Use: Know what the doctor's recommendations were as well as how the patient is actually using the lens.

Prescription & Measurements: This is going to consist of a detailed re-verification of power, axis, prism, add, segment height, optical center height, pupillary distance, and base curve of BOTH new and old glasses.

Lens Type & Material: Both you and your patient need to understand the changes and adaptations specific to lens design, technology, and material.

Lens Compensation and Position of Wear Measurements: If your prescription is reading differently than what was prescribed, maybe it is due to a lens compensation. Be sure to have the original lab invoice to understand the compensated Rx as well as any specified position of wear measurements used to derive this re-calculation.

Visual Acuities: New, Old, & Best Corrected: If you have access to a spare exam room or pretesting area that allows you to check acuities, many times this will save our doctor from a complete re-refraction. Know where to find in the exam records the best possible corrected vision because if there is a reason that clarity is reduced and is uncorrectable your evaluation might just be a review and confirmation that they are seeing as well out of the glasses as possible at this time.

Frequency and Consistency of Concern: If the glasses were amazing the first month and then all of the sudden stopped working, you need to know that. If a problem comes and goes, it could be a result of fatigue or medical changes.

Anisometropia: This is when the prescriptions are more than 2 diopters apart from each other. It is an important consideration because the further apart a prescription is the more crucial optical center alignment becomes in order to prevent unwanted prism. It also complicates any multifocal lens because when accessing the reading zone the eyes utilize a part of the lens that is far below the optical center thus creating double vision only when reading.

Medical Problems & Medications: It is not the optician's job to pry about personal medical history, especially if we are in the middle of a busy optical dispensary. However, it is important to review the chart and uncover a few key concerns that might raise questions and lead to a re-evaluation with the doctor.

Prescription tolerances are there for a reason. The human eye is not as sensitive of a receptor as we often give it credit for. There are certain forgiveness in any manufactured prescription that the human eye cannot detect. Yes, there are variations in your patient's sensitivity, but if you think you found the "a-ha" moment when you read your quarter cylinder off ten degrees, you may be wasting a remake.

Axis is not just for prescriptions, but also segment and progressive alignment. If the prescription is spot-on axis, but the progressive is tilted, the patient may not be aligning correcting in the near zone while reading. This can cause eye-strain and double vision.

A thorough visual examination of the lens can uncover waves or distortions. Also verifying the lens prescription should not end at the optical center or fitting height. You can actually observe how the prescription is changing in the lens by moving it around in your lensometer. You can observe how the sphere and cylinder lines change in outer regions of the lens identifying induced astigmatism and power changes that may be in line with the chief complaint. Some of this is normal in progressive designs, but the more you observe the periphery of lens types the more you will be able to identify when something wasn't surfaced correctly.

Prism needs to be verified whether it is prescribed or not. Progressives often have what is called prism-thinning. This is vertical prism read at the prism reference point and should match from one eye to the next. Often times induced prism cannot be verified until you mark the lens at the center pupil alignment on your patient's face and then read in your lensometer how much prism the patient is looking through.

When a prescription differs from eye-to-eye by more than 2 diopters, there are a few special considerations to be made. Optical center alignment is key to ensure the is no unwanted prism. A good rule of thumb is to align the optical centers in a single-vision lens about 2mm below the pupils for a standard frame tilt of about 8 degrees. With multifocals, you may have the distance optical centers aligned properly, but the reading zone is far enough away from that center to sometimes create prism in the bottom of the lens. How much will be determined by the prescription strength and corridor length or bifocal height. You can combat this image split by reducing your progressive corridor lengths to bring your near power higher in the lens. In the case of a lined bifocal, you need to keep your segment height at the lower lid or higher. In extreme cases where the prism induced in the near zone cannot be accommodated by the wearer, slab off prism may be needed. This adds opposing prism in just the lower portion of just one lens to bring the images together more easily for the patient.

Add powers need to be verified in your lensometer, not just by noting the laser marking. You need to make sure the full reading power is present in the lens as well as accessible to the patient. If segment heights are too low or the bottom of the lens sits too close to a person's cheeks, the add power may not be reachable with reasonable head tilt or eye turn.

Base curves should be measured with the lens clock placed vertically on the lens. If the

horizontal reading differs by a diopter or more you have a warped lens that can cause distortion. The cause is usually oversizing by the lab or excessive heat exposure and can be verified by measuring the lens again unmounted. It may be remedied easily by some skillful hand sizing. You also need to verify that base curves match what was ordered or what is appropriate for that particular prescription and frame design.

Asking about changes in health and medications as well as reviewing the medical chart is important because it can save you a lot of time and remakes if the underlying problem is not due to the glasses. Most patients will immediately attribute reductions in visual clarity to their glasses because that's what they associate with their quality of vision. However, there are many other factors internally that not only affect our eye health but can also cause refractive error or reduced acuities.

Cataracts reduce visual acuities by a clouding of the inter-ocular lens. Any amount of reduced light to the eye cannot be further corrected by a spectacle lens. Most of the time it will be seen at the exam and reviewed with the patient. As an optician you might need to re-clarify information regarding uncorrectable vision and the possible further development of the opacity of the lens until they are recommended for surgery. In some cases though, cataracts can develop very quickly and may not have been prevalent at the exam but only a few months after the dispense of the new glasses they can no longer see well out of them. This is a conclusion that would need to be identified by a follow-up visit with the doctor after you have made no conclusive cause for reduced vision in your thorough evaluation.

Corneal or retinal scarring should be noted in the exam record especially if it's a cause for uncorrectable vision.

Macular degeneration causes central vision loss. If a patient presents with loss of central vision and there are no apparent aberrations in the lens of the glasses, you may want to schedule a medical visit and visual field examination if they are not being currently monitored for MD. Diabetes can cause instability in a patient's prescription if glucose levels are not well controlled. As glucose levels increase, water can be retained creating edema or swelling of the lens and cornea causing the eye to have more curvature thus becoming more myopic.

Diabetes can also cause macular swelling which would have an opposite effect. As the macula swells, the axial length of the eye can shorten and make a patient more hyperopic, needing higher plus correction.

From congenital defects to disease to results of an accident, some patients are unable to move their head and neck freely which can impede the use of multifocals or require lenses to be positioned in very specific ways in front of their eyes to meet special needs. I have had patients with fused spines, exaggerated hunched backs or extremely pronounced vertigo. All of these require specific problem solving and consideration.

A woman who is pregnant or nursing may experience corneal edema, a swelling of the eye that again causes the eye to be more myopic. It can be a difficult diagnosis if a woman has

not already volunteered the information regarding pregnancy and it is not completely obvious.

Prednisone is used to treat allergic disorders, ulcerative colitis, psoriasis and arthritis. This and other strong steroids have many potential side effects including the development of cataracts and refractive changes.

Hormone treatment commonly used for menopause but may be prescribed for other reasons can cause severe dry eye and transient vision loss.

Our eyes are very sensitive to our overall health and can be affected by everything from chemo therapy to everyday stress.

The majority of evaluations I have done are able to be solved through adjustment. It is an amazing transformation and sometimes a tough sell when a patient comes in not being able to see out of their glasses to admitting that simple adjustments have solved the problem completely. Even when the phoropter in the exam had them seeing 20/15 and the lenses were manufactured correctly, the angle and distance at which it sits in front of the eye can cause the patient to interpret the prescription very differently.

Pantoscopic tilt is the angle that the lens is bent on the 180 degree axis. A lens is anatomically correct and aligned properly with the eye's optical axis at approximately 8-9 degrees of lens tilt. Increasing the lens tilt has many benefits that can be immediately recognized by your patient. It helps create a more parallel lens surface to reading material reducing distortion. It brings the reading zone of a multifocal closer to the eye creating a visibly wider zone through what many call the "keyhole" affect. It tucks in the Intermediate and near zone to appear to lower the segment height and allow the patient better distance vision. This tucking in of the lens makes the "soft focus" less accessible to the eye and makes it easier to look over the magnification for safer ground clarity without needing to bend the neck down as much. It also eliminates the distraction of being able to see under the lens.

We measure segment heights with pretty standard parameters, but different people with different lifestyles, who use their eyes in very different ways may fit outside of the standard fit preferences. That is why it is awesome to have the forgiveness of nose pad adjustments. Very tall people are likely to want lower fittings because most of their world is below them. Spread out the nose pads. Some people prefer to look straight out at the computer and don't mind tilting their head down to drive. Pinch in those pads. If the bridge or lens thickness doesn't allow you to make as much adjustment as you were hoping, fit the frame with extremely thin or fat pad to give yourself that extra millimeter that you need.

It becomes much more difficult to raise and lower frames with no adjustable pads, but not impossible. Removing the lenses and manipulating the molded bridge through heat can buy you a millimeter or two. I have even edged down some of the nasal portion of the lens in order to widen the bridge now molding to the new lens shape and lowering the frame front.

Just be sure not to change the aesthetics of the frame shape and no, those stick-on nose pads are never a solution. At some point you do need to remake the lenses.

Vertex is the distance at which the back of the lens sits from the front of the eye. It can be decreased and increased through nose pad adjustment or adding or flattening frame curvature. Minor changes in vertex can change the overall perceived power of the lens especially in higher prescriptions. Moving a lens closer to the eye increases minus and decreases plus. Perching the lens farther will decrease minus and increase plus. You can also provide better eyelash clearance, less cheek rub, or implement the “keyhole” affect with vertex adjustments.

Cylinder axis and progressive design or bifocal segment axis need to be considered and adjusted for often times simultaneously. Know your ANSI tolerances for both. Most corrections can be made through turning a lens in the frame. Never use axis pliers for this. It is not worth the scratched lens and doesn’t allow for the accuracy of unmounting and remounting a lens correctly. If your shape is too rectangular to allow for corrective turns, you can sometimes have a lens nest in the frame a few degrees different by edging down a sliver of opposite sides. For example, if you need your lens to tilt nasal up, edge a hair off the top of the lens on the nasal half and the bottom of the lens temporally. Do not attempt this if the lens is already sized too small however. If both lenses are nasal up or nasal down, a minor bridge angle adjustment can do the trick as long as it is not so much so that it causes a noticeable cat eye or droopy frame appearance. Last, make sure you recheck prescription axis in your lensometer and segment axis on a lens aligner. Your eyes can trick you.

Decreasing frame wrap can reduce distortion as well as changing the prismatic effect of a lens. Increasing frame wrap can bring “soft focus” out of the patient’s field of view and also effectively narrow the pupillary distance in the frames.

As lens designs have become more advanced and customizable, our amount of potential variables while problem solving have become more numerous and complex. The optician has to stay smarter than the lens. Most digital lens technology utilizes prescription compensation. This is an intentional recalculation of the original prescription taking into account how the frame is fit and worn.

Most compensated prescriptions change so little that they still fall within ANSI standards of tolerance. When you are verifying a lens with a higher Rx or extreme wrap you may have a very different result. You need to verify the prescription against the compensation provided by your lab as well as analyze the values for vertex, wrap, and panto that were provided for the order. The changes made to the prescription need to make sense with the prescription strength and parameters of the positions of wear.

Many lens technologies allow for other customizations. Specification of corridor length is a common one that can also be a handy tool for patient satisfaction. Don’t just let your segment height determine the progressive distribution. You need to take into account the primary uses of the lens through lifestyle questions and carefully examine the fit and shape

of the lens.

While it can give you much needed information to compare an old pair of glasses to a new one, make sure you don't automatically assume all changes are bad ones if the patient complains. You can't fit them in a Younger Image forever. Eventually the old molded des ign will be a thing of the past. However, there is a lot you can learn from comparison of the two. Because you are able to customize freeform technology, you are better off making the updated lens work better for their needs than resorting to a duplicate of their old style.

If the prescription was manufactured incorrectly and outside of ANSI tolerance and all other concerns have been addressed and ruled out, it is safe to remake the lenses as a lab error or optician entry error (whatever the case may be) without involving the doctor. If the prescription has been made accurately from the written Rx and all other possibilities have been ruled out, this is when a re-refraction may be needed.

Sometimes a patient will make up every excuse in the world to return a pair glasses short of saying "I just don't like them". Luckily, through this process you can rule out any actual inaccuracies in the lens manufacturing or prescribed Rx. Then you can start a very careful line of questioning to determine if a re-style of frame might be a possible solution. Sometimes this is due to pure vanity, but other times it may be a fit, weight, or adjustability issue. If it is simply a matter of price consciousness, be familiar with your office's return and exchange policy.

Being able to test your hypothesis before you remake the lens or schedule with the doctor is ideal. If you think a shorter corridor or higher seg height is what they need, ask them to hold the glasses up and see if that makes an improvement. If you think the problem may lie in the prescription strength, use flippers to add +/- 0.25 or 0.50 to see if it makes any noticeable improvement. As an optician, you can't make changes to the prescription, but you can review your findings with the doctor saving them time and building their trust in your abilities if you end up being right.

It's important to rule out as much as possible along the way. If you end up changing several things in a remake and the patient still has problems, then you don't know if you created new problems as a result. Comparisons of old and new glasses are great for ruling things out as well as testing specific scenarios of fit, height, and lens power.

You should never stop short of completing a thorough evaluation even if you have found a gross error or definitive solution. If you are sure you have to remake the lenses for a specific reason, you might as well refine any other measurements or finishing errors while you are at it. I know in the scientific method you want as few variables as possible to identify the true underlying problem and prove your hypothesis. However multiple remakes that change one thing at a time are costly and time consuming so you are better off getting it all fixed the first time.

How you present your solution is as important as finding it. There is no need to throw your co-workers, lab, or especially the doctor under the bus. It doesn't need to be anyone's fault,

they just need to know you are going to fix it. You also need to explain how you are fixing their lenses with as little technical jargon as possible. I make sure to stress that it is not uncommon for it to take a couple of tries in order to make the glasses preform best for how each person uniquely uses their eyes. Using a little honest spin and strategic verbiage while not outright lying is important to save face and credibility.

Keep your explanations simple and not accusatory. We are lucky to have to ability to customize and refine so many specifications in prescription lenses. There are also so many details that may not be fully considered at the time of sale that only surface through complaints after experiencing the new lenses. A simple apology for the inconvenience and promise to make it right is usually all the explaining needed.

This process is set up to use your opticians as the gate keepers that analyze and solve issues regarding adjustment, defects, prescription tolerances, lab errors, segment and optical center alignment, or further patient instruction and reassurance. Most of the time that time slot that you “saved” with the doctor will not be utilized. I will assure the patient that everything we spoke about and changed today will be reviewed with their doctor, but actual chair time is often unnecessary. The circumstances where the doctor has to be involved include any prescription changes or new medical concerns.

You should always approach your doctor with possible solutions instead of problems. For instance, if the patient is complaining they have to hold their reading material too close, ask them to hold it where they prefer and try -0.25 and -0.50 flippers to see if they notice an improvement. You can also measure the preferred focal distance and provide this information to the doctor. They may even feel confident enough in your experimentation to change the prescription through calculation and your recommendation alone. If you are ever in question of the need for intervention, always ask. Just discussing possible solutions and brainstorming with your doc will usually lead you to the correct answer. Medical issues can be tricky because it is not your job as an optician to diagnose anything concerning eye health. Changes can also happen quickly or fluctuate, so after you have ruled out the possibility of glasses fit and function, this is when you need to pass the torch.

After determining a probable root cause and evaluating all other variables you are ready to fix the problem. Always try to solve through adjustment first and test your hypothesis through experimentation. If you have no other choice than to refabricate the lenses, make it count. Remakes should be due to an intentional correction of fitting measurements, prescription changes, or lens design. It is never the right answer to just duplicate all of the details of their previous order because that is what they are used to. It’s tempting when stumped, but not generally the real solution. After all, why did they come to you for new glasses in the first place?

When reordering from your lab, be sure to double check all of your numbers and measurements before submitting to eliminate the chance of typos and more remakes. Always reference the original invoice and clearly highlight all changes being made. Make good notes on why you are making the changes in order to not repeat this process next year. Be honest about the reason for the remake. If it’s a typo, it’s an optician error not a

doctor's change. If the lenses are still useful to the patient, try to archive lenses only so they are not further inconvenienced.

Sometimes you will get that patient that is never going to be satisfied. If you have a clear sense of this or a pattern of multiple remakes with no end, save yourself the time and trouble by at least giving them the option of a buy-back of their glasses. I will usually put the ball in their court by saying, "We can either send this back to our lab correcting what we just talked about but I get the sense that some of the underlying concerns about this lens will still require some compromise and adaptation, or we would be happy to buy back your glasses." Not refund or return, this is a satisfaction guarantee not defeat or incompetence.

Each scenario of a dissatisfied patient will lead you to different solutions. Some obvious, some not expected. It is important to be thorough and sometimes even to think outside the box.

This is a patient who got his first pair of glasses at age 70 because the DMV sent him in due to not passing the vision screening. He has 2 diopters of cylinder and is adamant that he sees better without glasses. He has had these glasses for 4 months and has not even given them a chance because they instantly make him dizzy. What do you do?

First, all of the prescription parameters checked out great. I increased pantoscopic tilt and decreased frame wrap to try to alleviate the dizzy feeling. Then, I took him into the exam room and not only checked that he was meeting the doctor's expected acuities, but made a point to demonstrate that he does, indeed, see much better with each eye individually with the glasses on. We talked about perception and adaptation hurdles that will be tough but are normal and how they will not go away without regular wear. I also stressed that it is not legal for him to be driving without them. I made an alert to call him in a week with the understanding that he actually needed to have them on for all waking hours until then. At the follow-up, I got the very satisfying admition that they were much better and actually growing on him.

I had initially thought by the prescription comparison that this patient was not liking the reduced minus power. However, after testing acuities he was actually seeing 20/15 through the new prescription but still describing it as blurry and doubled. The bifocal segment Was fit intentionally per his request and when I dotted up the o.c. height, I saw that it was sitting a full 7mm below his pupils. The p.d. had also been made binocularly for aesthetic purposes in the placement of the segment on the lens. It turns out when a patient has very different monocular measurements, it causes unwanted prism.

I first demonstrated that lifting up the frame in front of his eyes was making an improvement in his vision. Then, I reordered the lenses, keeping the BF seg low, but specifying a higher o.c. height and monocular p.d.s.

This patient had already been back to our office for three adjustments. Since this was her first progressive lens, there was a constant re-assuring that there is an adjustment period. This is now 4 months later and she still has the same vague complaint of eye strain. The prescription was reading accurately and she was seeing 20/20 as expected in reading and

distance. Even though she was reading at 20/20, she said it felt strained. I asked her to nod her head up and down while reading and tell me if there was any improvement. She stopped while looking through the middle of the lenses and was relieved that it was clear and not strained. She was gazing through her intermediate zone.

This is when experimenting with trial lens "flippers" comes in handy. I told her to again look through the full magnification of the reading zone as I trial -0.25, -0.50, and -0.75 lenses in front of her glasses. After a clear preference for the -0.50 adjustment, I told her I would review our findings with the doctor and adjust the lenses accordingly. I always make it clear the I am not the one making prescription changes as I am not the doctor. I also am careful not to say things like, "looks like you may be over-plussed" which implies a mistake in the exam.

Here is a situation where the patient took their prescription elsewhere. It is important to always invite patients back for lens verification if you are releasing a prescription. Keeping your doors open to them can potentially win them back to your practice, especially if it leads you to pointing out gross errors made by a "low price leader".

This patient had initially taken her glasses back to Walmart where they re-verified the outside Rx and told her they were correct and it was likely the prescription that was wrong. I first addressed that the prescription filled was almost a year and a half old, and the doctor recommends a new exam yearly, especially before investing in new eyewear. That being said, I confirmed the Rx was indeed matching what the doctor had written. The errors were made in the measurements and manufacturing. It's not hard to identify that the pupillary distance in the clear pair was much too wide and induced 1 base-in unwanted prism per eye. To this she protested that her vision was much worse out of the sunglasses.

This is a large wrapped sunglass that was made at a bargain retailer and it is clear looking at the frame that it was intended for an 8-base wrapped lens. With a prescription like this and the technology we have available, a digital lens utilizing a wrap compensation would be the only way she could see well out of this selected frame. Instead, she had traditionally surfaced lens made on the highest curve the prescription would allow and then bent the frame at the bridge excessively to compensate. This causes extreme amounts of unwanted astigmatism. While the lens was clamped in the lensometer is read correctly, but if I unclamped it and saw the Rx as she was viewing it with the excessive wrap, the cylinder lines quickly mis-aligned. After giving her my analysis and writing up a recommendation for the Walmart optician, she decided to return the glasses. She got a new exam and glasses from us the next week.

It's not just about finding the solution but also making the process to getting there as efficient and painless as possible for both yourself and your patient. It's not always the easiest job handling all of the complaints and concerns of unsatisfied and upset patients but it will definitely get you in the good graces of the rest of the staff and especially the doctor if you hone your skills and prove your worth.