THE COLLEGE OF OPTOMETRISTS

Student guidance: CLiP 2 Face-to-face visit (CLiP 2F)

Assessment visit overview

When: Approximately 13 weeks from start of CLiP Part 2

Where: In the student's practice

Duration: 2 hours and 55 minutes (with an additional 15 minutes for Assessor to carry out patient consultation)

The visit will consist of five overarching tasks:

1. Complete eye examination
    a. History and symptoms
    b. Refraction
    c. Eye health assessment
    d. Binocular vision assessment
    e. Management plan (incl. supplementary tests)
    f. Record-keeping
2. Specialist dispense
3. Diagnosis: management and referral
4. Learning and development
5. Quality assurance of setting and supervision (for support purposes)

Quick reference for logbook requirements

Unlike previous visits, you do not need to assign many logbook entries to particular tasks in 2F.

Important note: Unlike the remote visit, the Assessor will be with you at your practice and will be able to see patient records on your screen in the testing room. As such, you should not need to anonymise records for this visit. However, do make sure that your visit is arranged in the main practice where your records are accessible.

For **Task 1** and **Task 2** you do not need to assign any logbook entries.

Task 3

- On your CLiP Portal Risk Dashboard, all areas must be showing **green**. In Task 3, Assessors will select from your whole logbook and ask you to show some related patient records. They will search for entries including items in the list below (see Task 3, below, for more detail).

  Anterior eye

  a. Cataract
  b. Red eye
  c. Dry eye
  d. Blepharitis

  Posterior eye

  a. Glaucoma
  b. Diabetic or hypertensive retinopathy
  c. Suspect retinal detachment
  d. Maculopathy

  Neurology and fields

- You don’t need to assign logbook entries to Task 3. However, it will be good to do logbook searches to check that you have entries for the range of conditions listed above and that you have included relevant details about diagnosis, management and referral in the related patient records.

Task 4

- An entry in which you upload the completed Personal Development Plan template you submitted for the previous visit, CLiP 2R.
- An entry in which you upload a new completed Personal Development Plan template for CLiP 2F.

Task 5

- An entry with the Supervisor Survey completed by your Supervisor and uploaded.
- You can complete the QA ‘Setting and supervision’ survey in the Assessment area of the Portal – this is not a logbook entry (see details in full logbook checklist, below).

Combining logbook requirements

There is no need to combine logbook requirements in your entries for this visit.

Relevant learning outcomes

In CLiP Part 2, you no longer need to record a learning outcome against each entry and explain how you met this in the consultation notes.

The tasks in CLiP Part 2 assessment visits are related to the GOC learning outcomes but, unlike the CLiP Part 1 visits, we do not need you to link to learning outcomes or write about how you met the outcomes as an assessment requirement.

In Task 3, the Assessor will select logbook entries and ask you to show the related patient records. As such, it is important that you continue to provide keywords about the interaction in the ‘Reference’ field, select relevant items in the drop-downs and write brief summaries in your ‘Consultation notes’ when you create daily logbook entries.

Preparing for the visit

You can also refer to our student handbook for more information on how to prepare for assessment visits. Here are some key points:

4-5 weeks before the visit

- Make sure your assessment visit has been arranged in the main practice where your patient records can be accessed on screen in the testing room.
- Start checking your readiness for the assessment using the **quick-reference logbook requirements** list above.
- Go back to your University notes and learning materials to **revise potential topics** covered in the visit – in particular the areas listed in Task 3 (see details below).
- Review and discuss the **Personal Development Plan** template with your supervisor and start completing this.
- Check your visit date and time, make sure you have it recorded and that your employer knows about it.
- Arrange with your supervisors and other colleagues to **observe** you in clinical practice with patients.

2-3 weeks before the visit

- As you get nearer to the visit date, you can use the more detailed **full logbook checklist**, below, for all the details of what you need to select and upload in the CLiP Portal for this visit.
- In preparation for Task 3 (see details below) do searches for the keywords Assessors will be looking for and spot-check your patient records.
- Review and complete your **Personal Development Plan**.
- Arrange with a supervisor to **observe** you in practice for Task 1 of CLiP 2F – try to use the CLiP 2F record card and follow the stages of the visit examination.
- Make sure you and your Supervisor complete the **surveys** (see instructions in the full logbook checklist, below).

1 week before the visit

- The deadline for having all your logbook entries ready and approved on the CLiP Portal is **one week** in advance of your visit time.
- Arrange with your supervisor to **observe** you in practice for Task 1 of CLiP 2F mock-exam style.

Week of the visit

- Check that everything is arranged for your assessment in the practice:
  - the practice support staff know the mystery patient is coming and are aware that they are not booked on the system like a standard patient;
  - you have a testing room available for the assessment;
  - the testing room has a computer on which the Assessor will be able to see patient records you need to show; and

On the day

- Have your own **photo ID** ready to show the Assessor.
- Have a print-out of the **2F Record card**.

- Get your testing room **ready for the visit** and make sure you are ready to show the Assessor any in-practice patient records they ask to see.

Outline of each task

Task 1 – Complete eye examination

1 hour allowed for this task (50 minutes for eye exam and 10 minutes to discuss with Assessor).

A 'mystery shopper' patient will be arranged who is presbyope, with a specified ocular health and prescription range.

Before your assessment starts, your Assessor will review the mystery shopper's details, including their prescription and history, and carry out a basic ocular health check using the slit lamp (SLE). The Assessor will take about 10 minutes for this part of the visit but it does not come out of your assessment time.

The Assessor will then read a set of instructions asking you to carry out the following:

- Perform pupil assessments and motility checks.
- Carry out retinoscopy and record your retinoscopy results as soon as you have completed it.
- Refract your patient using either a trial frame or a phoropter.
- Perform binocular balancing, if appropriate, for your patient
- Carry out the internal and external examination either before or after the refraction
- Note any supplementary tests you would propose on the record template (you do not need to perform these tests).
- Include the recall for the patient on the record template.

You'll complete a **record template** for this task rather than creating a record in your practice system. You will need to successfully complete and pass each sub-task of Task 1. You also need to complete this clinical examination within the 50 minute time limit. If you go over this time, the Assessor will stop you and move on, even if you have not finished.

If you make minor mistakes or leave out small details during the clinical examination, the assessor may ask you additional scenario-based questions to check whether you meet the required standards.

(a) History and symptoms

The Assessor will observe you taking history and symptoms with the mystery shopper patient. The Assessor will check that you ask appropriate questions for all relevant areas set out below, and that you use effective strategies and follow-up questions to get the information you need:

- RFV, vision and symptoms
- OH and FOH
- GH, medication and FGH
- symptom check
- driving
- lifestyle/ work

- CL information (if applicable)
- smoker

(b) Refraction

The Assessor will observe you refracting the patient. You will need to use an appropriate retinoscopy technique and achieve accurate results, being defined as:

- accurate results for retinoscopy within +/- 1.00 DS/DC (determined using a power cross) and axis appropriate to cylinder

Static fixation retinoscopy is the expected technique, but if you prefer or need to use one eye only then you must use a valid and appropriate technique for monocular viewing e.g. Barrett Method or Near Fixation retinoscopy.

You will need to use an appropriate subjective refraction routine and achieve accurate results, being defined as:

- accurate results for subjective within +/- 0.50 DS/DC (determined using a power cross) and axis appropriate to cylinder if patient VA 6/9 or better

You are allowed to use either a trial frame or a phoropter. You will need to demonstrate that you:

- Achieve accurate near add and range appropriate to needs
- Use appropriate methods of checking, if required, e.g. +1.00Ds blur or use of pin-hole
- Understand the relationship between vision and Rx, and symptoms and Rx, making appropriate prescribing and management decisions based on the refractive and oculomotor status.

(c) Eye health assessment

You will be observed assessing the patient's anterior and posterior eye, and neurological health, using appropriate techniques and a range of illumination techniques, appropriate brightness and magnification. You will need to examine:

- the external eye and adnexa
- lashes
- bulbar conjunctiva
- palpebral conjunctiva
- Anterior Chamber Angle
- Lens and media
- Pupil Reactions
- Fundus (inc. thorough and systematic scanning)

(d) Binocular vision assessment

The Assessor will observe you undertaking objective tests (including cover) using suitable targets and assessing deviation accurately, to include:

- direction of latent or manifest deviation
- speed of recovery
- size – small, moderate or large
- concomitant / incomitant

(e) Management plan (incl. supplementary tests)

You will need to formulate a management plan for the patient and communicate it clearly to them. The Assessor will check that you:

- Use the clinical data you gather during the examination, along with the patient's presenting symptoms, to formulate an appropriate management plan.
- Understand the link between vision, prescription (Rx), and symptoms.
- Make prescribing and management decisions that are appropriate based on the patient's refractive and oculomotor status.
- Communicate clearly by giving factually accurate information in a way the patient can easily understand. Avoid jargon and technical terms whenever possible.

When you give the patient advice, the Assessor will check that you understand the limitations of your knowledge and refer the patient if necessary, and also that you recognise and document the need for any further clinical investigations such as visual fields or IOPs, if appropriate.

At this point in the task, the observation is complete and the mystery patient is allowed to leave.

(f) Record-keeping

The Assessor will take the record template you have recorded the examination on and check that you have:

- Fully and accurately recorded all the information related to the patient – your findings and your management plan.
- Produced a record which is legible and contains all the patient's details, measurements, results and advice.

Task 2 – Specialist dispense

20 minutes allowed for this task

The Assessor will present you with scenarios involving two separate fictional patients: one with specialist occupational needs and one needing contact lens dispense.

The Assessor will present their requirements, choosing from a wide choice of patient needs, combining variants of background/occupation/hobby with corrective requirement and dispense type.

You will be asked to analyse their needs and set out how you would prescribe, dispense and form a clinical management plan. The Assessor will ask you follow-up questions where required.

Task 3 – Diagnosis: management and referral

1 hour and 10 minutes allowed for this task

This task is based on review and discussion of your logbook entries and in-practice patient records, supplemented by assessor toolkit images and simulated scenarios.

The Assessor will select and discuss **five** conditions from those listed below (including at least **one** from each of categories 1, 2 and 3) by searching your full logbook.

1. Anterior eye
    e. Cataract
    f. Red eye
    g. Dry Eye
    h. Blepharitis
2. Posterior eye
    a. Glaucoma
    b. Diabetic or hypertensive retinopathy
    c. Suspect retinal detachment
    d. Maculopathy
3. Neurology and fields

The Assessor will discuss with you at least three entries with referrals and compare these with similar cases in which a referral was not made, to explore your decision-making. For each entry, you will be asked to explain your findings and decision-making, in a style appropriate to communicating with another healthcare professional.

The Assessor will also use images (of pathologies not already covered by the logbook entries) to explore differential diagnosis outcomes with you. The Assessor will present you with at least **one** from each category (Anterior, posterior, neurology and fields) including:

- common ocular conditions: e.g. cataract, diabetic retinopathy, hypertensive retinopathy, age-related maculopathy, retinal detachment, tilted disc, red eye, conjunctivitis
- less common conditions: e.g. retinitis pigmentosa, anisocoria, BCC, corneal ulcer, endothelial dystrophy, ONH swelling, uveitis, angle closure glaucoma
- visual fields

For each of these cases, the Assessor will ask you to:

a. describe what you see in language that could be used in a referral letter to another health care professional
b. give a provisional diagnosis
c. outline any further tests that would be helpful before deciding on management

d. decide on best management giving appropriate urgency, and pathway, if onward referral is required.

At least **twice** during these discussions, the Assessor will ask you to communicate your findings to them as if they were the patient or their carer.

Task 4 – Learning and development

15 minutes allowed for this task

The Assessor will review your submitted Personal Development Plan forms (the one from your 2R visit and the new completed PDP form) and discuss these with you, noting any developments and changes between the two visits.

The Assessor will expect you to reflect on your progress throughout CLiP and your degree. If the Assessor finds gaps in your learning needs analysis or the actions you have planned, they will explore your ability to suggest appropriate amendments to improve your PDP.

Task 5 – Quality assurance of setting and supervision (for support purposes)

10 minutes allowed for this task

The Assessor will discuss your responses to the QA survey and will also discuss the Supervisor's questionnaire with them. The focus will be on signposting further information and support, where required.

This task is for support purposes and will not be assessed with a Pass/Fail outcome.

We suggest that you also look at the full marking criteria and learning outcomes in the **CLiP Assessment Handbook**.

Full logbook checklist

For entries you want the Assessor to review, assign the correct assessment visit task in the **Task** field of the logbook entry.

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
3	With reference to the risk profile table and your Risk Dashboard, all areas must be showing **green** as a prerequisite for Task 3 in CLiP 2F. Assessors will select from your whole logbook and ask you to show related patient records. They will look for entries based on anterior and posterior eye conditions, neurology and fields – see Task 3, above, for more detail.	Not required	No	No
4	**One** logbook entry with copy of Personal Development Plan document from the **2R** assessment visit. In Logbook entry > Assessment tasks **the following is selected:** • CLiP 2 (Face-to-Face visit) 4 Learning and Development **Upload attachment:** completed PDP template used at the 2R visit with 'PDP – 2R' in 'Reference' field and/or doc filename.	Not required	No	No
4	**One** logbook entry with new version of Personal Development Plan document for the **2F** assessment visit. In Logbook entry > Assessment tasks **the following is selected**: • CLiP 2 (Face-to-Face Visit) 4 Learning and Development **Upload attachment:** completed PDP template with 'PDP – 2F' in 'Reference' field and/or doc filename.	Not required	No	No

Task	Logbook entry requirements	Link to learning outcome?	Anonymise in-practice patient record?	Can entries be combined?
5	**One** logbook entry: a survey for the 'Setting and supervision' discussion with the Assessor needs to be completed by your Supervisor in advance of the visit – template can be downloaded from the College website. In Logbook entry > Assessment tasks **the following is selected**: • CLiP 2 (Face-to-Face Visit) 5 Quality assurance of setting and supervision (for support purposes) **Upload** attachment – completed Supervisor survey.	Not required	No	No
5	The **student survey** for the 'Setting and supervision' discussion with the Assessor needs to be completed in advance of the visit, although this is not assessed. You can complete the student survey in the CLiP Portal, but this is a part of the **Assessment form**, not an upload to the logbook. To complete the 'Setting and supervision' survey, go to your Assessment Form in the CLiP Portal: • Main menu > Assessments • Double-click on your visit details • Use 'Go to Assessment Form' button • Click on the tab for 'Setting and Supervision Survey' in top right • Complete survey and click 'Next' • Confirm and Submit the form	Not required	No	No

More guidance and resources

You can find these templates for this visit on our website CLiP Resources page:

- CLiP 2F record card
- Personal Development Plan template
- Supervisor survey

You can read more about logbook entries, the CLiP Portal and preparing for visits in our **CLiP Student Handbook**.

You can see the full marking criteria that your Assessor will use in the **CLiP Assessment Handbook**.

All Handbooks are available on the CLiP Resources page.

Document version	Date	Update
1.1	13/03/2026	First version
1.2	29/04/2026	Points deleted from Task 1(c)
1.3	08/05/2026	Changes to quick ref, Task 1 task list revised,
2.1	24/06/2026	Task timings amended: 15 mins for patient review, task 2 changed to 20 mins; task 3 changed to 1 hr 10; task 4 changed to 15: overall now 2 hrs 55