I. Evaluation for FV12 Treatment

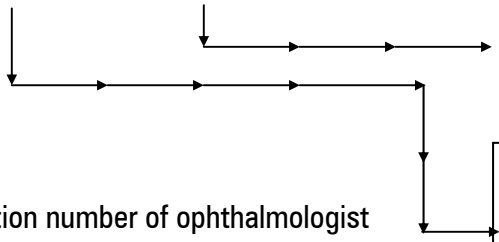
NOTE: *This section of the FV12 Treatment Form must be completed for* ***all*** *patients in the CAPT Study.*

1. Which eye was randomized to CAPT treatment?

( )$_0$ Right ( )$_1$ Left

2. Will this eye be treated at FV12 in accordance with the CAPT protocol?

( )$_0$ No ( )$_1$ Yes



2A. If YES, complete questions 3 and 4 **and** Section II of this form.

3. Print name and certification number of ophthalmologist performing evaluation for re-treatment:

_____ / __ __ __ __
Name Cert#

4. Date of FV12 treatment evaluation:

__ __ - __ __ - __ __
Month Day Year

2B. If, NO, check best reason:

- Less than the equivalent of 10 large drusen in this eye ( )$_1$
- Presence of CNV or serous PED in either eye ( )$_2$
- Reading Center recommends no further protocol treatment ( )$_3$
- Patient unwilling to be retreated ( )$_4$
- New Geographic Atrophy $<$500 microns to foveal center or $\geq$ 1 MPS Disc Areas ( )$_5$
- Other, specify: ( )$_6$

a. _____

Complete questions 3 and 4. Since patient will not be treated, do not complete Section II of this form.

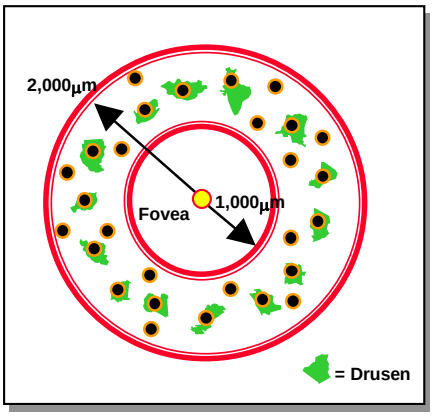
Coord Ctr Use Only: Initials__ __ __
Date: __ __ - __ __ - __ __

Visit: 12 Form: TE	ID. No.: __ __ - __ __ __ - C Name Code: __ __ __ __ __

II. FV12 Treatment

NOTE: *This section must be completed for patients treated at FV12 according to CAPT protocol.*

FV12 Treatment Pattern



1. Eye treated? ( )$_0$ Right ( )$_1$ Left

2. Date treatment was performed:

   __ __ - __ __ - __ __
   Month Day Year

3. Specify contact lens used and indicate spot size setting on laser: (check one)

   Goldmann, Mainster Standard or Volk Area Centralis with a 100µ setting on laser ( )$_1$

   Panfunduscopic, Volk TransEquator or Mainster Wide Field with a 75µ setting on laser ( )$_2$

   Volk QuadrAspheric, Mainster Ultra Field PRP or Volk SuperQuad 160 with a 50µ setting on laser ( )$_3$

   Volk SuperMacula 2.0 with a 200µ setting on laser ( )$_4$

   Other lens and/or spot size setting (specify) ( )$_5$ →

   3A. Specify lens and spot size setting on laser:
   _____
   _____

4. Which wavelength laser was used?
   a. Argon green ( )$_1$
   b. Other wavelength ( )$_1$ →

5. Indicate each duration of exposure used:
   a. 0.1 second ( )$_1$
   b. Other ( )$_1$ →

   4A. Describe: _____
   _____

   5A. Describe: _____
   _____

<u>NOTE</u>: For the following two questions, include all burns applied regardless of whether a visible lesion was created.

6. Number of test burns applied **outside** the area designated for protocol treatment: __ __

7. Total number of burns applied **within** the area designated for protocol treatment: __ __

8. Any laser treatment complications?

( )$_1$ Yes ( )$_0$ No

9. Print name and certification number of ophthalmologist performing treatment:

_____ / __ __ __ __
Name Cert#

8A. Specify complication:
a. Hemorrhage ( )$_1$
b. Other, specify: ( )$_1$
c. _____

10. Date the treatment stereo color photographs were taken:

__ __ - __ __ - __ __
Month Day Year

Treatment photographs (stereo color photographs and stereo red-free color photographs of the macula) should be taken promptly following treatment, but no later than 2 days following treatment.

11. Print name and certification number of photographer taking the treatment stereo color photographs:

_____ / __ __ __ __
Name Cert#

12. Print name and certification number of clinic coordinator checking form for completeness:

_____ / __ __ __ __
Name Cert#

13. Date checked for completeness:

__ __ - __ __ - __ __
Month Day Year