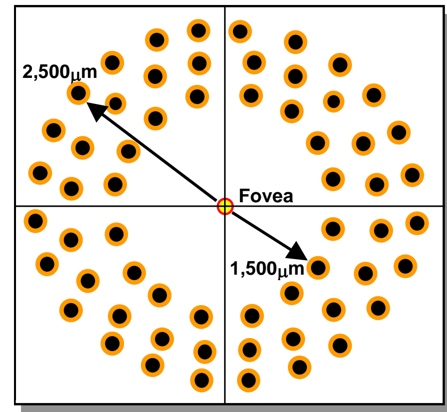
Complications of Age-related Macular Degeneration Prevention Trial
INITIAL LASER TREATMENT FORM

NOTE: *This form must be completed for all patients in the CAPT Study.*

Initial 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 →

   4A. Describe: ______________________________

   ____

5. Indicate each duration of exposure used:
   a. 0.1 second ( ) 1
   b. Other ( ) 1 →

   5A. Describe: ______________________________

   ____

NOTE: 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: __ __

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

Visit: 00 Form: TR	ID. No.: __ __ - __ __ __ - C Name Code: __ __ __ __ __

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

8. Any laser treatment complications?
   ( )1 Yes ( )0 No

8A. Specify complication:
   a. Hemorrhage ( )1
   b. Other, specify: ( )1
   c. ______________________

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

   ______________________ / __ __ __ __
   Name Cert#

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

Visit: 00 Form: TR	ID. No.: __ __ - __ __ __ - C Name Code: __ __ __ __ __