***NOTE**: Refer to the relevant section and question number from the Initial Visit form. Fax Checklist to Coordinating Center.*

Clinic Number: __ __ Site Number: __ ID. Number: __ __ - __ __ __ - C Name Code: __ __ __ __ __

EYE Characteristics

(To be confirmed by the Ophthalmologist after review of angiogram)	**RIGHT EYE**		**LEFT EYE**	
	Yes	No	Yes	No
V.1. 10 or more large drusen (>125μ) within 3000μ of foveal center	( )	(STOP)	( )	(STOP)
V.2. Geographic atrophy >1 MPS disc area within 3000 microns of the foveal center	(STOP)	( )	(STOP)	( )
V.2. Geographic atrophy within 500 microns of the foveal center	(STOP)	( )	(STOP)	( )
V.3. Signs of diabetic retinopathy worse than 10 red dots or macula edema	(STOP)	( )	(STOP)	( )
V.4. Retinal changes related to high myopia	(STOP)	( )	(STOP)	( )
V.5. Glaucoma likely to affect central vision within 5 years	(STOP)	( )	(STOP)	( )
V.7a. Lens removal or implantation less than three months ago	(STOP)	( )	(STOP)	( )
V.7b. Capsulotomy within the past three days	(STOP)	( )	(STOP)	( )
V.8. Any lens opacity that will preclude good photography	(STOP)	( )	(STOP)	( )
V.9. Evidence of CNV now or in the past	(STOP)	( )	(STOP)	( )
V.10. Serous Pigment Epithelial Detachment	(STOP)	( )	(STOP)	( )
V.11. Previous laser photocoagulation treatment to the retina	(STOP)	( )	(STOP)	( )
V.12. Any other ocular disease	(****)	( )	(****)	( )

Date approved by Reading Center: __ __ - __ __ - __ __
Month Day Year

PATIENT ELIGIBILITY

	Yes	No	Yes	No
II.3.o. & 4.o. Visual acuity total number correct 43 (20/40) or better	( )	(STOP)	( )	(STOP)
VI.2. & 5. Color stereo photographs and fluorescein angiogram taken Photo date: __ __ - __ __ - __ __ (Month Day Year) FA date: __ __ - __ __ - __ __ (Month Day Year)	( )	(STOP)	( )	(STOP)
Was all required visual function testing completed within 28 days prior to randomization?	( )	(STOP)	( )	(STOP)

Clinic Number: __ __ Site Number: __ ID. Number: __ __ - __ __ __ - C Name Code: __ __ __ __ __

PATIENT ELIGIBILITY (continued)

		Yes	No
I.3.	Age 50 years or older	( )	(STOP)
I.7.-8.	Exclusionary history of macular toxic drugs	(STOP)	( )
I.17a.	Condition that makes 5-year survival unlikely	(STOP)	( )
I.17b.	Limits to activity making follow-up unlikely	(STOP)	( )
I.17c.	Signed informed consent form	( )	(STOP)
I.15.	Participating in any other study	(****)	( )

Approved by Coordinating Center: _____
Name

		Yes	No
V.6.	Currently taking macular toxic glaucoma drugs	(STOP)	( )

CLINIC Responsibilities

		Yes	No
1.	Complete Patient Information questionnaire	( )	(STOP)
2.	Complete Initial Visit Form	( )	(STOP)
3.	Complete Quality of Life Assessment	( )	(STOP)
4.	Any reservations about enrolling this patient	(STOP)	( )
5.	Check here if a Pre-randomization Review was submitted to the Reading Center	( )	
6.	Check here if the patient is also enrolled in AREDS:	( )	

6A. AREDS Registration Number: __ __ __ __ __ __

6B. AREDS Name Code: __ __ __ __ __ __

7. Print name and certification number of ophthalmologist reviewing this checklist: _____ / __ __ __ __
Name Cert