I. Interim History

***Note**: To be completed by the clinic coordinator by directly questioning the patient. Sentences within quotes should be read verbatim to the patient.*

1. "Which of your eyes has better vision, or would you say there is no difference?"

   ( )$_0$ Right ( )$_1$ Left ( )$_2$ No Difference

2. "Are you aware of spots in your vision?"

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

   → 2.A. Which eyes have the reported spots:
   - a. Right only ( )$_0$
   - b. Left only ( )$_1$
   - c. Both eyes ( )$_2$
   - d. Not sure which eye ( )$_3$

3. Has the patient had any laser treatment to the retina other than CAPT IV treatment or FV12 treatment since the last CAPT visit?

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

   → 3.A. Specify type of laser treatment (check all that apply):

	Right	Left
a. Treatment of CNV with confluent laser burns	( )$_1$	( )$_1$
b. Treatment of CNV with photodynamic therapy	( )$_1$	( )$_1$
c. Treatment of vein occlusion	( )$_1$	( )$_1$
d. Other, specify below:		
1. _____	( )$_1$	( )$_1$
2. _____	( )$_1$	( )$_1$

4. Other treatment since last CAPT visit (for each eye check either "None" or all that apply):

	Right	Left
a. None	( )$_1$	( )$_1$
b. Lensectomy	( )$_1$	( )$_1$
c. Capsulotomy	( )$_1$	( )$_1$
d. IOL implant	( )$_1$	( )$_1$
e. Other, specify below:		
1. _____	( )$_1$	( )$_1$
2. _____	( )$_1$	( )$_1$

5. Print name and certification number of person who completed this section:

   _____ / __ __ __ __
   Name Cert#

6. Date Interim History was completed:

   __ __ - __ __ - __ __
   Month Day Year

Coord Ctr Use Only: Initials__ __ __ Date: __ __ - __ __ - __ __	Visit: __ __ Form: FV
	ID. No.: __ __ - __ __ __ - C Name Code: __ __ __ __ __

II. Visual Acuity Examination

NOTE: <u>Both</u> eyes of the patient must be tested. Circle each correct letter and put an X on each incorrect letter. Leave letters not attempted unmarked.

1. Correction obtained by subjective refraction (If Plano, enter zeros):
   a. Right Eye:
   + / − __ . __ __ + __ . __ __ X __ __ __
   Circle Sign Sphere Cylinder Axis

   b. Left Eye:
   + / − __ . __ __ + __ . __ __ X __ __ __
   Circle Sign Sphere Cylinder Axis

2. Letters read correctly at 3.2-meter distance:

RIGHT EYE - CHART 1

Acuity Equivalent	Chart 1 Letters	Number Correct
a. 20/250	N C K Z O	_____
b. 20/200	R H S D K	_____
c. 20/160	D O V H R	_____
d. 20/125	C Z R H S	_____
e. 20/100	O N H R C	_____
f. 20/80	D K S N V	_____
g. 20/64	Z S O K N	_____
h. 20/50	C K D N R	_____
i. 20/40	S R Z K D	_____
j. 20/32	H Z O V C	_____
k. 20/25	N V D O K	_____
l. 20/20	V H C N O	_____
m. 20/16	S V H C Z	_____
n. 20/12	O Z D V K	_____
o. Total number correct		__ __

p. Is (2.o.) total number correct 16 or more?
( )$_1$ Yes ( )$_0$ No

2.A. Letters read correctly at 1.0-meter distance:

RIGHT EYE - CHART 1

Acuity Equivalent	Chart 1 Letters	Number Correct
a. 20/800	N C K Z O	_____
b. 20/640	R H S D K	_____
c. 20/500	D O V H R	_____
d. 20/400	C Z R H S	_____
e. 20/320	O N H R C	_____
f. Total number correct		__ __

3. Letters read correctly at 3.2-meter distance:

LEFT EYE - CHART 2

Acuity Equivalent	Chart 1 Letters	Number Correct
a. 20/250	D S R K N	_____
b. 20/200	C K Z O H	_____
c. 20/160	O N R K D	_____
d. 20/125	K Z V D C	_____
e. 20/100	V S H Z O	_____
f. 20/80	H D K C R	_____
g. 20/64	C S R H N	_____
h. 20/50	S V Z D K	_____
i. 20/40	N C V O Z	_____
j. 20/32	R H S D V	_____
k. 20/25	S N R O H	_____
l. 20/20	O D H K R	_____
m. 20/16	Z K C S N	_____
n. 20/12	C R H D V	_____
o. Total number correct		__ __

p. Is (3.o.) total number correct 16 or more?

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

3.A. Letters read correctly at 1.0-meter distance:

LEFT EYE - CHART 2

Acuity Equivalent	Chart 1 Letters	Number Correct
a. 20/800	D S R K N	_____
b. 20/640	C K Z O H	_____
c. 20/500	O N R K D	_____
d. 20/400	K Z V D C	_____
e. 20/320	V S H Z O	_____
f. Total number correct		__ __

4. Did the examiner have any information on which eye was assigned to CAPT treatment?

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

5. Print name and certification number of examiner:

_____ / __ __ __ __
Name Cert#

6. Date of visual acuity testing:

__ __ - __ __ - __ __
Month Day Year

Visit: __ __ Form: FV	ID. No.: __ __ - __ __ __ - C Name Code: __ __ __ __ __

III. Contrast Sensitivity Testing

NOTE: Both eyes of the patient must be tested at 1 meter. Add +.5 diopters to patient's refractive correction at 3.2 meters. Circle each correct letter and put an X on each incorrect letter. Leave letters not attempted unmarked.

RIGHT EYE - Chart 4L										LEFT EYE - Chart 2L									
				Number Correct					Number Correct					Number Correct					Number Correct
1a.	V	R	S	____	2a.	K	D	R	____	3a.	H	S	Z	____	4a.	D	S	N	____
1b.	N	H	C	____	2b.	S	O	K	____	3b.	C	K	R	____	4b.	Z	V	R	____
1c.	S	C	N	____	2c.	O	Z	V	____	3c.	N	D	C	____	4c.	O	S	K	____
1d.	C	N	H	____	2d.	Z	O	K	____	3d.	O	Z	K	____	4d.	V	H	Z	____
1e.	N	O	D	____	2e.	V	H	R	____	3e.	N	H	O	____	4e.	N	R	D	____
1f.	C	D	N	____	2f.	Z	S	V	____	3f.	V	R	C	____	4f.	O	V	H	____
1g.	K	C	H	____	2g.	O	D	K	____	3g.	C	D	S	____	4g.	N	D	C	____
1h.	R	S	Z	____	2h.	H	V	R	____	3h.	K	V	Z	____	4h.	O	H	R	____

5. Print name and certification number of examiner:

_____ / __ __ __ __
Name Cert#

6. Date of contrast testing:

__ __ - __ __ - __ __
Month Day Year

Visit: __ __ Form: FV	ID. No.: __ __ - __ __ __ - C Name Code: __ __ __ __ __

IV. Reading Test

NOTE: <u>Both</u> eyes of the patient must be tested at 40cm. Add +2.00 diopters to patient's refractive correction at 3.2 meters. Put an X on each incorrect word. Record time to nearest tenth of a second and the number of errors. Check all boxes for sentences not attempted. If a technical error (e.g. stopwatch malfunction) occurs during a sentence, code time as XX.X and errors as XX. Maximum time allowed is 99.9 seconds per sentence. Patient must attempt to read sentence for a minimum of 30 seconds before you end the test.

1. The reading test is required for FV36 and FV60. This is visit FV __ __. The reading test ( )$_1$ ( )$_0$ required.
Is Is Not

RIGHT EYE -- Chart 1

		Not Attempted	Time	Errors
1R.	My father takes me to school every day in his big green car.	☐	__ __ . __	__ __
2R.	Everyone wanted to go outside when the rain finally stopped.	☐	__ __ . __	__ __
3R.	They were not able to finish playing the game before dinner.	☐	__ __ . __	__ __
4R.	My father asked me to help the two men carry the box inside.	☐	__ __ . __	__ __
5R.	Three of my friends had never been to a circus before today.	☐	__ __ . __	__ __
6R.	My grandfather has a large garden with fruit and vegetables.	☐	__ __ . __	__ __
7R.	He told a long story about ducks before his son went to bed.	☐	__ __ . __	__ __
8R.	My mother loves to hear the young girls sing in the morning.	☐	__ __ . __	__ __
9R.	The young boy held his hand high to ask questions in school.	☐	__ __ . __	__ __
10R.	My brother wanted a glass of milk with his cake after lunch.	☐	__ __ . __	__ __
11R.	I do not understand why we must leave so early for the play.	☐	__ __ . __	__ __
12R.	It is more than four hundred miles from my home to the city.	☐	__ __ . __	__ __
13R.	Our father wants us to wash the clothes before he gets back.	☐	__ __ . __	__ __
14R.	They would love to see you during your visit here this week.	☐	__ __ . __	__ __
15R.	The teacher showed the children how to draw pretty pictures.	☐	__ __ . __	__ __
16R.	Nothing could ever be better than a hot fire to warm you up.	☐	__ __ . __	__ __
17R.	The old man caught a fish here when he went out in his boat.	☐	__ __ . __	__ __
18R.	Our mother tells us that we should wear heavy coats outside.	☐	__ __ . __	__ __
19R.	One of my brothers went with his friend to climb a mountain.	☐	__ __ . __	__ __

LEFT EYE -- Chart 2

		Not Attempted	Time	Errors
1L.	The three elephants in the circus walked around very slowly.	☐	__ __ . __	__ __
2L.	We could not guess what was inside the big box on the table.	☐	__ __ . __	__ __
3L.	The two friends did not know what time the play would start.	☐	__ __ . __	__ __
4L.	She wanted to show us the new toys she got for her birthday.	☐	__ __ . __	__ __
5L.	The mother told her son that she wanted him to go to school.	☐	__ __ . __	__ __
6L.	An old man took a picture of my sister and her little puppy.	☐	__ __ . __	__ __
7L.	Ten different kinds of flowers grow by the side of the road.	☐	__ __ . __	__ __
8L.	Put your first name on this paper if you will help tomorrow.	☐	__ __ . __	__ __
9L.	The father gave his children some fruit for lunch every day.	☐	__ __ . __	__ __
10L.	Please do not make noise while they are reading their books.	☐	__ __ . __	__ __
11L.	We sometimes take long walks together if it is warm outside.	☐	__ __ . __	__ __
12L.	The snow fell softly this morning before our family woke up.	☐	__ __ . __	__ __
13L.	Many people came to help us clean the place after the party.	☐	__ __ . __	__ __
14L.	He could see a bird outside if he looked through his window.	☐	__ __ . __	__ __
15L.	The teacher wanted the children to learn how to draw a boat.	☐	__ __ . __	__ __
16L.	We like to listen to music when we are eating our breakfast.	☐	__ __ . __	__ __
17L.	Three of my closest friends are going to visit him tomorrow.	☐	__ __ . __	__ __
18L.	She gave a glass of water to her mother before going to bed.	☐	__ __ . __	__ __
19L.	My brother was not feeling very well so he did not go today.	☐	__ __ . __	__ __

20. Print name and certification number of examiner:

_____ / __ __ __ __
Name Cert#

21. Date of reading testing:

__ __ - __ __ - __ __
Month Day Year

Visit: __ __ Form: FV	ID. No.: __ __ - __ __ __ - C Name Code: __ __ __ __ __

V. Ophthalmological Evaluation

NOTE: <u>Both</u> eyes must be evaluated. If an angiogram is obtained, send it to the Reading Center with a Reading Center Exudative Event Form whether exudation is confirmed or not.

1. Is there ophthalmoscopic evidence of exudation in the <u>right</u> eye?
   ( )$_1$ Yes ( )$_0$ No

2. Is there ophthalmoscopic evidence of exudation in the <u>left</u> eye?
   ( )$_1$ Yes ( )$_0$ No

3. Are there any ocular problems that could account for a decrease in visual acuity in either eye?
   ( )$_1$ Yes ( )$_0$ No

4. Print name and certification number of ophthalmologist:

   _____ / __ __ __ __
   Name Cert#

5. Date of ophthalmologic exam:

   __ __ - __ __ - __ __
   Month Day Year

OBTAIN A FLUORESCEIN ANGIOGRAM AND SEND IT TO THE READING CENTER

1.A. Is the presence of CNV or serous PED confirmed on angiography? ( )$_1$ Yes ( )$_0$ No

1.A.a. Is this the first confirmation of exudation? ( )$_1$ Yes ( )$_0$ No

COMPLETE EXUDATIVE EVENT FORMS FOR THE COORDINATING AND READING CENTERS

OBTAIN A FLUORESCEIN ANGIOGRAM AND SEND IT TO THE READING CENTER

2.A. Is the presence of CNV or serous PED confirmed on angiography? ( )$_1$ Yes ( )$_0$ No

2.A.a. Is this the first confirmation of exudation? ( )$_1$ Yes ( )$_0$ No

COMPLETE EXUDATIVE EVENT FORMS FOR THE COORDINATING AND READING CENTERS

3.A. Check all that apply:

	Right	Left
a. Cataract	( )$_1$	( )$_1$
b. Geographic atrophy	( )$_1$	( )$_1$
c. Other, specify below:		
1. _____	( )$_1$	( )$_1$
2. _____	( )$_1$	( )$_1$

VI. Photographs

1. Have the following required stereo color photographs been taken:

   a. Right eye macula? ( )$_1$ Yes ( )$_0$ No

   b. Left eye macula? ( )$_1$ Yes ( )$_0$ No

   1.A. Why Not: _____

   _____

   1.B. Why Not: _____

   _____

2. Date the stereo color photographs were taken:

   __ __ - __ __ - __ __
   Month Day Year

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

   _____ / __ __ __ __
   Name Cert#

4. A fluorescein angiogram is required at FV12, FV24, FV36, FV48, FV60 and FV72 or if, at FV06, exudation is suspected in either eye. Select the status of angiography for this visit:

   a. Not required ( )$_1$
   b. Required, angiogram taken ( )$_2$
   c. Required, angiogram not taken ( )$_3$

   4.A.a. Date fluorescein angiogram taken:

   __ __ - __ __ - __ __
   Month Day Year

   4.A.b. Print name and certification number of photographer taking angiogram:

   _____ / __ __ __ __
   Name Cert #

   4.B. Why not? _____

   _____

   _____

Visit: __ __ Form: FV	ID. No.: __ __ - __ __ __ - C Name Code: __ __ __ __ __

VII. Administrative Matters

1. The next visit must be scheduled at this time, fill in date:

   __ __ - __ __ - __ __
   Month Day Year

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

   _____ / __ __ __ __
   Name Cert#

3. Date checked for completeness:

   __ __ - __ __ - __ __
   Month Day Year

INSTRUCTIONS FOR CLINIC COORDINATOR

SEND ORIGINALS TO COORDINATING CENTER

Coord Center Transmittal Log ❑
Followup Visit Form ❑

At FV12, send

FV12 TR Evaluation Form ❑

At FV60, send

Quality of Life Assessment ❑

SEND ORIGINALS TO READING CENTER

(Send All Materials Together)

Photographic Materials Transmittal Log ❑
Color Photographs ❑
Photograph Inventory Form ❑
Fluorescein Angiograms (as required) ❑

KEEP IN YOUR CLINIC FILES

Copies or Duplicates

All Data forms ❑
All Transmittal Logs ❑
All Photographs ❑
All Photograph Inventory Forms ❑
All Required Fluorescein Angiograms ❑

Visit: __ __ Form: FV	ID. No.: __ __ - __ __ __ - C Name Code: __ __ __ __ __