I. Interim History

NOTE: *This form should be completed when a patient is unable or unwilling to return to the CAPT clinic for a scheduled visit but is willing to allow release of this information from another ophthalmologist. This form should be filled out as completely as possible from history notes or a summary of the patient's visit provided by the outside ophthalmologist. For items that are not covered, please check the box for unknown. The original form should be sent to the Coordinating Center within two weeks of completion and a copy retained in the clinic files.*

1. Outside visit date:

   __ __ - __ __ - __ __
   Month Day Year

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

   ( )$_0$ No ( )$_1$ Yes ( )$_2$ Unknown

   2.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. _____	( )$_1$	( )$_1$

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

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

II. Visual Acuity Examination

NOTE: If available, complete visual acuity of each eye.

1. Snellen equivalent: Check if unknown:

   a. Right eye: __ __ / __ __ __ ☐

   b. Left eye: __ __ / __ __ __ ☐

2. Date of visual acuity testing: Check if unknown:

   __ __ - __ __ - __ __ ☐
   Month Day Year

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

III. Ophthalmological Evaluation

NOTE: Both 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 right eye?

( )$_0$ No ( )$_1$ Yes ( )$_2$ Unknown

OBTAIN A FLUORESCEIN ANGIOGRAM AND SEND IT TO THE READNG 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

2. Is there ophthalmoscopic evidence of exudation in the left eye?

( )$_0$ No ( )$_1$ Yes ( )$_2$ Unknown

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

3. Are there any ocular problems that could account for a decrease in visual acuity in either eye?

( )$_0$ No ( )$_1$ Yes ( )$_2$ Unknown

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. _____	( )$_1$	( )$_1$

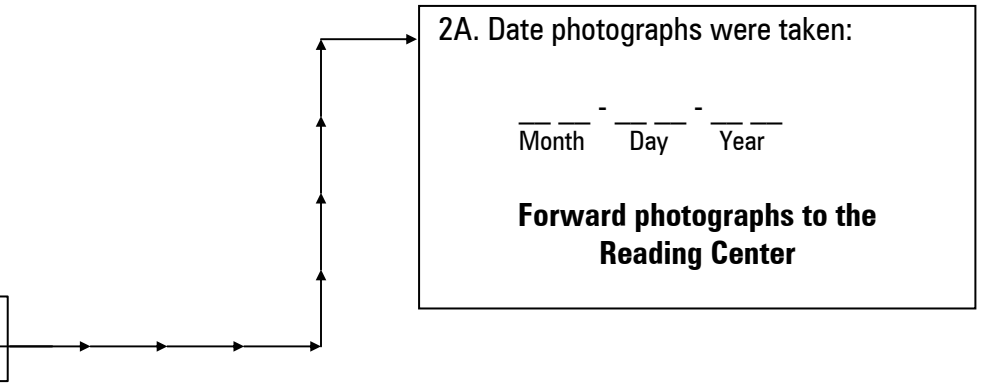
IV. Administrative Matters

1. Date information obtained:

   __ __ - __ __ - __ __
   Month Day Year

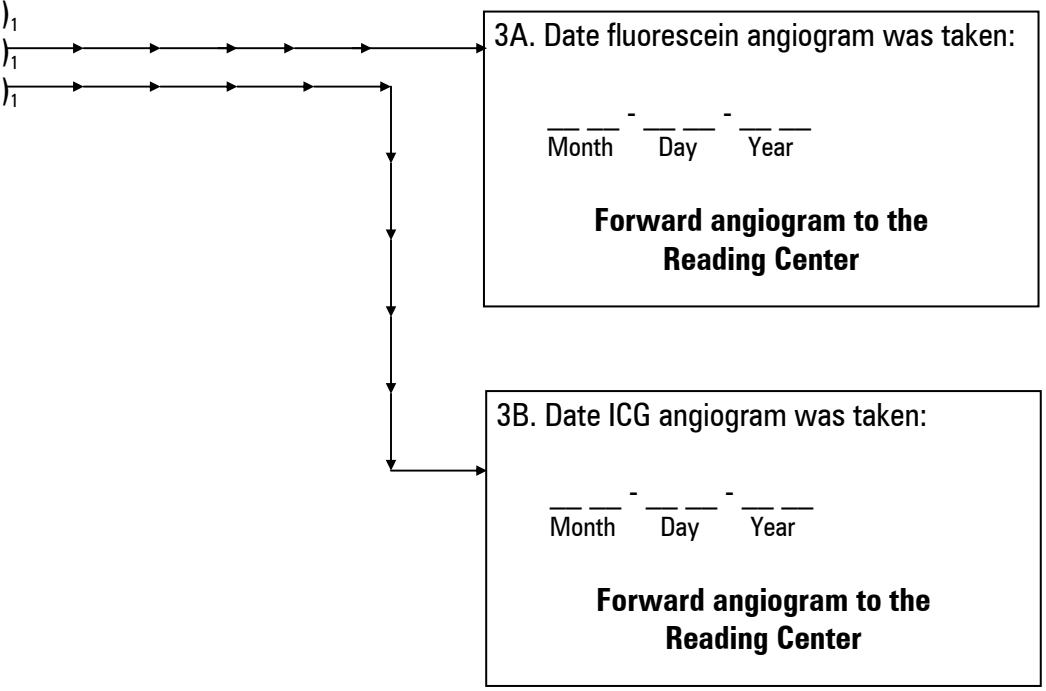
2. Are color photographs available?

   a. None ( )0
   b. Right Eye Only ( )1
   c. Left Eye Only ( )2
   d. Both Eyes ( )3



3. Is an angiogram available?
   (check any that apply)

   a. None ( )1
   b. Fluorescein ( )1
   c. ICG ( )1



4. Was a letter received from the outside ophthalmologist summarizing the examination findings?

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

Do not send the letter to the Coordinating Center. Please attach the letter to the copy of this form to be kept at the Clinic.

5. Print name and certification number of Clinic Coordinator checking form for completeness:

_____ / __ __ __ __
Name Cert#

6. Date checked for completeness:

__ __ - __ __ - __ __
Month Day Year

INSTRUCTIONS FOR CLINIC COORDINATOR

SEND ORIGINALS TO COORDINATING CENTER

Coord Center Transmittal Log ❑
Outside Visit Form ❑

SEND ORIGINALS TO READING CENTER

(Send All Materials Together)

Photographic Materials Transmittal Log ❑
Color Photographs (if applicable) ❑
Photograph Inventory Form ❑
All Fluoresceins (if applicable) ❑

KEEP IN YOUR CLINIC FILES

Copies or Duplicates

All Data forms ❑
All Transmittal Logs ❑
All Photographs (if applicable) ❑
All Fluoresceins (if applicable) ❑
All Photograph Inventory Forms ❑

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