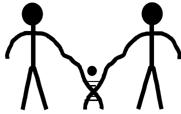


# FIND TRANSMITTAL LOG, EYE EXAM FORM & INVOICE
## Examination Form Completed from Chart

***For each patient, please complete the log, the eye exam form, and the invoice. Send them, together with the photos, to:***

**Kathy Glander, FIND Project Manager**
**Fundus Photograph Reading Center**
**406 Science Drive, Suite 400**
**Madison, WI 53711-1068**
**TEL: (608) 263-6983**
**FAX: (608) 263-0525**
**glander@rc.ophth.wisc.edu**

**Participant #**

01 __ __ __ __ __ __ __ __
FIND Location Participant ID

**Date of Most Recent Visit**

__ __/__ __ __/__ __ __ __
Day Month Year
*(e.g., 04/AUG/2000)*

**Included in this shipment are:**

☐ **Eye Exam Form (2 pages)**

☐ **Invoice**

**Shipment date:** __ __ / __ __ __ / __ __ __ __
Day Month Year
*(e.g., 04/AUG/2000)*

**Clinic contact person for questions regarding this shipment:**

Name: ____________________________________________

Phone: ______________________________ E-mail: ________________________

Comments/Explanation:

______________________________________________________________________________

______________________________________________________________________________

For UW-FPRC Use

Date received Date faxed Date entered

# FIND Study Eye Exam Form - Completed from Chart

**Participant #**

01 __ __ __ __ __ __ __ __
FIND Location Participant ID

1. Date of most recent visit: __ __/__ __ __/__ __ __ __ (Day Month Year) (*e.g., 04 / AUG / 2000*)
2. Date of birth: __ __/__ __ __/__ __ __ __ (Day Month Year) (*e.g., 04 / AUG / 2000*)
3. Year diabetes was **diagnosed**: __ __ __ __ (Year) **NR** ☐ **NR = Not recorded in chart**
4. Is the patient currently **taking insulin**? **Yes** ☐ **No** ☐ **NR** ☐
5. Did the patient start insulin **within 1 year of diagnosis**? **Yes** ☐ **No** ☐ **NR** ☐

| | **Right Eye** | **Left Eye** |
|---|---|---|
| 6. Has the patient ever had **retinal** photocoagulation (**laser treatment**)? | **Yes** ☐ **No** ☐ | **Yes** ☐ **No** ☐ |
| If yes: year of first treatment | __ __ __ __ Year | __ __ __ __ Year |
| 7. Has the patient ever had a **pars plana vitrectomy**? | **Yes** ☐ **No** ☐ | **Yes** ☐ **No** ☐ |
| If yes: year of first vitrectomy | __ __ __ __ Year | __ __ __ __ Year |
| 8. Has the patient had **cataract surgery**? | **Yes** ☐ **No** ☐ | **Yes** ☐ **No** ☐ |
| 9. Is the patient under treatment for **glaucoma**? | **Yes** ☐ **No** ☐ | **Yes** ☐ **No** ☐ |
| 10. Has the patient had any **other eye surgery**? | **Yes** ☐ **No** ☐ | **Yes** ☐ **No** ☐ |
| If yes, specify | _________ | _________ |
| 11. **Visual acuity** (Snellen equivalent) with current correction | **20/____** | **20/____** |
| **If worse than 20/40,** add pinhole, otherwise leave blank | **20/____** with ph | **20/____** with ph |
| 12. **Intraocular pressure** (mmHg) | __ __ | __ __ |

| 13. Ophthalmoscopic examination | **Right Eye** | **Left Eye** |
|---|---|---|
| If the fundus cannot be observed, check here and go to item 14. | ☐ | ☐ |
| A. **Retinopathy Severity Level**, check the **highest** level for each eye | | |
| 1. No retinopathy | ☐ | ☐ |
| 2. Microaneurysms (Ma) only | ☐ | ☐ |
| 3. Ma plus retinal hemorrhages and/or exudates (lipid deposits and/or cotton wool spots) | ☐ | ☐ |
| 4. Moderately severe to severe non-proliferative retinopathy, defined as **at least one** of the following:<br>a. definite venous beading<br>b. obvious intraretinal microvascular abnormalities<br>c. hemorrhages / Ma ≥ Std. 2A in at least two quadrants **(see page 3 for Std. 2A)** | ☐ | ☐ |
| 5. Proliferative retinopathy or status post panretinal (scatter) photocoagulation | ☐ | ☐ |

## FIND Study Eye Exam Form - Completed from Chart (continued)

**Participant #**

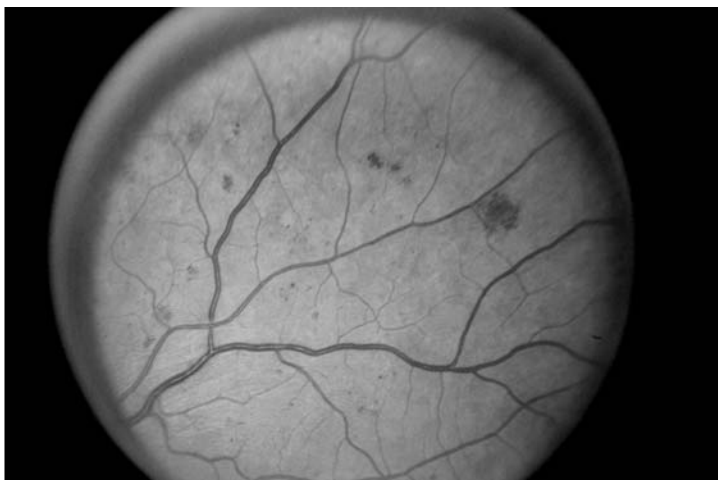
01 __ __ __ __ __ __ __ __
FIND Location Participant ID

| | **Right Eye** | | **Left Eye** | |
|---|---|---|---|---|
| B. Are **scars of panretinal photocoagulation** (or local photocoagulation, presumably for new vessels) present? | **Yes** ☐ | **No** ☐ | **Yes** ☐ | **No** ☐ |
| C. Are **scars of focal or grid photocoagulation for macular edema** present? | **Yes** ☐ | **No** ☐ | **Yes** ☐ | **No** ☐ |
| D. Is **macular edema** present (retinal thickening, with or without lipid deposits, within one disc diameter of the center of the macula)? | **Yes** ☐ | **No** ☐ | **Yes** ☐ | **No** ☐ |
| If yes, is **center of macula involved**? | **Yes** ☐ | **No** ☐ | **Yes** ☐ | **No** ☐ |
| 14. **Is visual acuity worse than 20/40 (with pinhole, if used)?** | **Yes** ☐ | **No** ☐ | **Yes** ☐ | **No** ☐ |

**If yes,** please indicate primary and any contributing causes.
Check as many as are applicable.
(P = primary, C = contributing)

| | Right Eye | | Left Eye | |
|---|---|---|---|---|
| A. Proliferative retinopathy | **P** ☐ | **C** ☐ | **P** ☐ | **C** ☐ |
| B. Diabetic macular edema | **P** ☐ | **C** ☐ | **P** ☐ | **C** ☐ |
| C. Cataract | **P** ☐ | **C** ☐ | **P** ☐ | **C** ☐ |
| D. Other (or no cause apparent) | **P** ☐ | **C** ☐ | **P** ☐ | **C** ☐ |

______________________________________________
**(please print)** Name & title of person completing exam form from chart



ETDRS Standard Photograph Number 2A

# FIND Study

## INVOICE for Services of Collaborating Eye Care Provider
### Examination Form Completed from Chart

Ref. UW P.O. #__________________

**Participant #**

01 __ __ __ __ __ __ __ __
FIND Location Participant ID

**Date of most recent visit**

__ __/__ __ __/__ __ __ __
Day Month Year
(*e.g., 04/AUG/2000)*

**Amount: $50.00**

Payee Name ______________________________

Payee Address ______________________________

______________________________

______________________________

______________________________

Phone ______________________ Fax ______________________

Tax ID # ______________________
(Required for Payment)

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Departmental Contact:

Kathy Glander, FIND Project Manager
Fundus Photograph Reading Center
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Madison, WI 53711-1068
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