

Macular Evaluation Report

Date	d a y / m o n t h / y e a r
To	
Patient's Name	F i r s t n a m e / L a s t n a m e
Date of Birth	d a y / m o n t h / y e a r
AHCIP #	
Appointment	d a y / m o n t h / y e a r
Reason for Referral	
VA unaided / aide	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU
History	<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Gastrointestinal
	<input type="checkbox"/> Allergies:
	<input type="checkbox"/> Other:
Medications	
Allergies	
Symptoms	<input type="checkbox"/> Decreased Visual Acuity <input type="checkbox"/> Distortion <input type="checkbox"/> Scotoma <input type="checkbox"/> Blurring

MACULAR EVALUATION		
	Right Eye	Left Eye
Drusen		
Fluid		
Blood		
Lipid		
Scarring		
Amsler Grid		

Intraocular Pressure	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> mmHg @ <input type="checkbox"/> NCT / Appl.
Refraction	<input type="checkbox"/> OD <input type="checkbox"/> (20/)
	<input type="checkbox"/> OD <input type="checkbox"/> (20/)
Diagnosis/Additional Information	
Signed	