



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

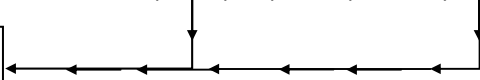
Clinic Number: \_\_\_ Site Number: \_\_\_ ID. Number: \_\_\_ - \_\_\_ - C Name Code: \_\_\_\_\_

**EYE Characteristics**

(To be confirmed by the Ophthalmologist after review of angiogram)

	<u>RIGHT EYE</u>		<u>LEFT EYE</u>	
	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: ___ - ___ - ___      FA date: ___ - ___ - ___	( )	(STOP)	( )	(STOP)
Month    Day    Year                      Month    Day    Year				
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
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- |  |        |     |
|--|--------|-----|
| 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