



# CATT FOLLOW-UP STUDY

## AMD External Care Review

ER (109.2)

02/12/2014

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ID. No.: \_\_\_\_ - \_\_\_\_ Alpha Code: \_\_\_\_

1. How many times did the patient see an external ophthalmologist for AMD care or for complications for their AMD?

\_\_\_\_\_ times or, if unknown, check here ☐

2. Please review with the patient the following list of AMD treatments. For each eye, indicate that either no AMD treatments were received OR check each type of treatment received and record an estimate of the number of times the treatment was administered.

**Right Eye****Left Eye**

a. Check if no AMD treatments in eye

☐☐

Right Eye			Left Eye	
If eye treated, check all treatments that apply	Estimate number of treatments	Check if number is unknown	Estimate number of treatments	Check if number is unknown
<input type="checkbox"/> b. Avastin injections	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/> c. Lucentis injections	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/> d. Eylea injections	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/> e. Triamcinolone injections	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/> f. Macugen injections	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/> g. Photodynamic therapy sessions	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/> h. Thermal laser sessions	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/> i. Other treatment, specify: _____	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/> j. Other treatment, specify: _____	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>
<input type="checkbox"/> k. AMD Treatment received but specific treatment is not known	_____	<input type="checkbox"/>	_____	<input type="checkbox"/>



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3. Is the patient willing to sign a medical release of information for the external ophthalmology visits?

☐<sub>1</sub> Yes \_\_\_\_\_ →

☐<sub>0</sub> No

Please have the patient sign a medical release form and request ophthalmology exam records from provider. When records are received, complete the AMD External Visit Log.

4. Last name and certification number of person who completed this form:

a.PRINT Last Name: \_\_\_\_\_

b.Certification #: \_\_\_\_

5. Date form was completed:

\_\_\_\_ - \_\_\_\_ - 201  
Month Day Year