Pre-Randomization Review
Submission of Photographs for Reading Center Review

Clinic #: _____ **Site #** _____ **Location:** _____

Name Code of Patient: __ __ __ __ __

Date of Color Photographs: __ __ - __ __ - __ __ (Month Day Year) **REQUIRED FOR ALL REVIEWS**

Date of Angiogram: __ __ - __ __ - __ __ (Month Day Year) **REQUIRED FOR ALL REVIEWS**

Ophthalmologist requesting review: _____
Please print

I. Reason for submission: (check all that apply)

	Right Eye	Left Eye
1. Number of drusen	☐1	☐1
2. Location of drusen	☐1	☐1
3. Basal laminar drusen	☐1	☐1
4. Drusenoid PED vs. S-PED	☐1	☐1
5. Presence of CNV	☐1	☐1
6. Area of Geographic Atrophy	☐1	☐1
7. Location of Geographic Atrophy	☐1	☐1
8. Acceptable photographs	☐1	☐1
9. Other ocular disease (Describe status of disease progression in comments)	☐1	☐1
10. Other (Specify in comments)	☐1	☐1

Comments from Investigator:
Right Eye:

Left Eye:

II. Reading Center Response:

Eligible for CAPT:
☐1 Yes ☐0 No

Reason NOT eligible: (check all that apply)

	Right Eye	Left Eye
1. Number of drusen	☐1	☐1
2. Location of drusen	☐1	☐1
3. Basal laminar drusen	☐1	☐1
4. Presence of S-PED	☐1	☐1
5. Presence of CNV	☐1	☐1
6. Area of Geo. Atrophy	☐1	☐1
7. Location of Geo. Atrophy	☐1	☐1
8. Unacceptable photographs	☐1	☐1
9. Other Ocular Disease	☐1	☐1
10. Angiogram required & not sent	☐1	☐1
11. Other (Specify in comments)	☐1	☐1

Comments from RC:
Right Eye:

Left Eye:

Materials submitted by: _____ Date: __ __ - __ __ - __ __
Please print (Month Day Year)

Phone # _____ FAX # _____

Date Received at Reading Center: __ __ - __ __ - __ __ (Month Day Year)

Eligibility Determination Complete: __ __ - __ __ - __ __ (Month Day Year)

Date clinic notified: __ __ - __ __ - __ __ (Month Day Year)

Grader: ___ __ __ - __ __ - __ __

Grader: ___ __ __ - __ __ - __ __

Reviewer: ____
__ __ - __ __ - __ __

Person notified: _____

Photographs returned to clinic: __ __ - __ __ - __ __ (Month Day Year)

☐ Data Entry Complete