

Pre-Screening Questionnaire

Efficacy of the Telescopic Mirror Implant for Age-related Macular Degeneration: The MIRROR Trial

The following questionnaire will be used to assess eligibility for the MIRROR Trial. Please take this form to your optician/ low vision clinic/ optometrist/ ophthalmologist/ GP for completion.

Name:		Please return completed form to: <Insert site address>
Address:		
POSTCODE:		
Date of birth:		
Health and care number:		
Name of GP/Optometrist:		

	<i>Please circle as appropriate</i>	
	Right Eye	Left Eye
Diagnosis	Wet AMD / Dry AMD	Wet AMD / Dry AMD
Best Corrected Visual Acuity	_____	_____
Has patient attended for treatment to Macular service?	Yes / No	Yes / No

Date of last intravitreal therapy (if applicable/known)	<hr/>	<hr/>
Lens status	Phakic/ pseudophakic	Phakic/ pseudophakic
Has patient required treatment for glaucoma?	Yes/No	Yes/No

General health for age	Poor / Average / Good
General mobility for age	Poor / Average / Good

I consent for my details to be sent to my nearest recruitment site			
Signature of patient:		Date:	

Signature of GP/Optomtrist:		Date:	
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Thank you for taking the time to complete this Pre-Screening Questionnaire.

The completed questionnaire should be sent to your nearest MIRROR study site where it will be assessed for eligibility.