Retinal Evaluation Policy and Consent

Dilated Retinal Exam

Dilation is an essential procedure which allows your doctor to temporarily enlarge your pupils using eye drops for a more extensive view of the inside of the eye. **All new patients to our practice usually require a complete dilated exam.** Some patients may experience blurred vision and light sensitivity, usually lasting 3-6 hours. In most cases distance vision will be minimally affected, however if you feel more comfortable being driven please make arrangements. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision. **There is no additional charge for dilation.**

PLEASE CHECK ONE OF THE FOLLOWING:

____ I **allow** ModernEYES Optical to dilate my pupils today if professionally indicated.

____ I am **unable** to have my pupils dilated today but **will schedule a follow-up dilation** within 30 days.

____ I **refuse** dilation of my pupils today and am **unwilling** to return. I understand that the dilation of my pupils is an important diagnostic tool that allows for a complete and thorough eye examination. I understand that by refusing dilation, I risk having a sight threatening disorder or other disease left undiagnosed. I also understand that if my medical history warrants dilation, my doctor may insist on the procedure in order to continue with the examination.

3D OCT Retina Wellness Screening

We are pleased to provide our patients with the most advanced technology available in retinal imaging today. **The OCT Wellness Screening simultaneously provides a digital photo and a 3D cross-section scan through the layers of your central retina using light waves**. The wellness screening is fast, easy, and comfortable. The doctor will review the results with you at today's visit. The wellness screening does not replace dilation, instead they work beautifully together for a more complete evaluation. The **fee** for this state of the art imaging procedure is **$29.99** .

PLEASE CHECK ONE OF THE FOLLOWING:

____ I **elect** to have a 3D OCT Wellness Screening of my retina.

____ I **decline** the Wellness Screening.

_____ _____

Signature of Patient (or Parent/Guardian if patient under 18) **Date**