WELCOME to Select Eyecare - Loganville

Select Eyecare LLC

Authorization for Diagnostic Ocular Health Tests

1. **DILATION –** Highly recommended to evaluate the health of your retina. Drops are used to enlarge the pupils. You will have blurred near vision and light sensitivity for 4-5 hours. There is no additional fee for dilation.

○ Yes, I consent to dilation ○ No, I do not consent to dilation

2. **OPTICAL COHERENCE TOMOGRAPHY (OCT) -** The Topcon 3D OCT-1 Maestro System provides the latest diagnostic technology available to allow your doctor to examine different layers of the retina. This instrument looks microscopically at the layers of the retina for early signs of macular degeneration, diabetes, glaucoma, vascular disease, medication toxicity & other conditions.

It is cutting-edge, advanced technology for viewing the retina or optic nerve. This enables your doctor to see underneath the retina and identify problems that cannot be seen with the naked eye and creates a digital record of the health of your retina.

The procedure is painless, takes minutes and has no side effects. **The OCT screening fee is $30.**

○ Yes, I consent to OCT screening ○ No, I do not consent to OCT

3. **VISUAL FIELD ANALYSIS –** This highly sophisticated computerized instrument is recommended by your doctor to check your peripheral vision and determine if there is any disease of the inside the eye or behind the eye extending into the brain that would be otherwise undetectable. This instrument also enables the doctor to better diagnose the cause of headaches and can detect glaucoma up to four years earlier than if this test was not performed.

You should strongly consider this test if:

You or a blood relative has glaucoma, macular degeneration, diabetes, hypertension, headaches, unexplained vision loss or are taking medications which could cause vision loss (Plaquenil/hydroxychloroquine for example). **The visual field screening fee is $20.**

○ Yes, I consent to a visual field ○ No, I do not consent to a visual field

4. Are you interested in advanced treatment procedures for **Dry Eye Syndrome**?

○ Yes ○ No

Patient Name

Date

mm/dd/yyyy

Patient Signature