

TELE DIABETIC RETINOPATHY SCREENING

Office use: / Centre:

Instruction: Where check boxes are provided, check (√) one or more boxes. Where radio buttons are provided, check (√) one box only.

* i) Site (machine location) : _____ * iii) Date of fundus photography (dd/mm/yy): / /

* ii) Site (where patient is from) : _____

* iv) Photo taken by : Family Medication Specialist (FMS) Medical Assistant (MA) Jururawat Masyarakat (JM)
 Doctor (Dr) Staff Nurse (SN) Radiographer (Rad)

SECTION 1 : PATIENTS DEMOGRAPHY AND MEDICAL HISTORY (to be filled by operator)

1. Patient Name : *													
2. Identification Card Number : *		MyKad / MyKid: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>								Old IC: <input type="text"/>			
If MyKad/MyKid not available, please complete the Old IC or Other ID		Other ID document No: <input type="text"/>						Specify type (eg.passport, armed force ID): <input type="text"/>					
3. Age of notification : *		4. Gender: <input type="radio"/> Male <input type="radio"/> Female		5. Ethnic Group: <input type="radio"/> Malay <input type="radio"/> Orang Asli <input type="radio"/> Iban <input type="radio"/> Chinese <input type="radio"/> Melanau <input type="radio"/> Bidayah <input type="radio"/> Indian <input type="radio"/> Kadazan/Murut/Bajau <input type="radio"/> Other, specify: _____									
6. Type of DM : <input type="radio"/> Type II <input type="radio"/> Type I		7. Pregnancy : <input type="radio"/> Yes <input type="radio"/> No											
8. Treatment : <input type="radio"/> Oral Medication Only <input type="radio"/> Insulin Only <input type="radio"/> Oral Medication + Insulin <input type="radio"/> Other, specify : _____													
9. Visual Acuity : *		a) Right eye <input type="text"/>				b) Left eye <input type="text"/>							
10. Photo Taken : *		<input type="radio"/> Both eyes <input type="radio"/> Right eye only <input type="radio"/> Left eye only		If photo of one eye or both eyes are not taken or not saved due to poor quality, reason : <input type="text"/>						<input type="checkbox"/> No Red Reflex <input type="checkbox"/> No View <input type="checkbox"/> No Eyeball <input type="checkbox"/> Other, specify: _____			

SECTION 2 : DIAGNOSIS AND MANAGEMENT PLAN (to be filled by grader)

1. Date of Grading : * (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/>											
DIAGNOSIS				MANAGEMENT PLAN							
<input type="checkbox"/> Inadequate view for grading ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye				<input type="radio"/> Call patient to repeat fundus photo <input type="radio"/> Refer eye clinic on : a) Date of appointment : (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/> b) Time of appointment : <input type="text"/> : <input type="text"/>							
<input type="checkbox"/> No apparent diabetic retinopathy : ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye				Give appointment to repeat fundus photo at KK in : <input type="radio"/> One year <input type="radio"/> If pregnant, every 3 months							
<input type="checkbox"/> Mild non proliferative diabetic retinopathy : ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye				Give appointment to repeat fundus photo at KK in : <input type="radio"/> 9 months <input type="radio"/> One year <input type="radio"/> If pregnant, every 3 months							
<input type="checkbox"/> Moderate non proliferative diabetic retinopathy : ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye				Give appointment to repeat fundus photo at KK in : <input type="radio"/> 6 months <input type="radio"/> 9 months <input type="radio"/> If pregnant, every 3 months							
<input type="checkbox"/> Severe non proliferative diabetic retinopathy : ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye				i. Refer eye clinic on : a) Date of appointment : (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/> b) Time of appointment : <input type="text"/> : <input type="text"/>							
<input type="checkbox"/> Proliferative diabetic retinopathy : ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye				ii. Treatment planned : <input type="checkbox"/> Laser <input type="checkbox"/> Fundus Fluorescein Angiography (FFA)							
<input type="checkbox"/> Advanced diabetic eye disease : ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye				i. Refer eye clinic for further assessment on : a) Date of appointment : (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/> b) Time of appointment : <input type="text"/> : <input type="text"/>							
<input type="checkbox"/> Maculopathy : ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye											
<input type="checkbox"/> Glaucoma suspect : ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye											
<input type="checkbox"/> Age related macular degeneration : ↳ <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye											
<input type="checkbox"/> Other fundus findings : ↳ <input type="checkbox"/> Right eye, state : _____ <input type="checkbox"/> Left eye, state : _____											
<input type="checkbox"/> Vision worse the 6/12 in either eye				Refer to Optometrists for refraction							

Date of referral letter faxed out: (dd/mm/yy) / /

Patient seen at referring eye clinic Yes No → a) Date seen : (dd/mm/yy) / /

Instruction : The status is known only after the date of appointment given. Data is captured from eye clinic counter when the patients being refererd come for appointment and status to be entered to Tele DR