



EYE HEALTH ASSESSMENT

As part of the comprehensive eye examination there are two ways that our doctors can thoroughly assess the health of the back of your eyes (also known as the retina):

- 1 ***OPTOMAP Retinal Exam and iWellness Scan. (The doctors' preferred method)***
 These painless and non-invasive procedures provide your doctor with a detailed view of the back of the eyes as well as beneath the surface of the retina without the use of dilation drops. This information can help in the early detection of common eye diseases such as diabetic retinopathy, glaucoma and macular degeneration. The images and scans become a part of your permanent medical file, enabling your doctor to make important comparisons should vision threatening conditions show themselves at a future examination. Insurances do not cover these screening scans and there is a co-payment of \$39.00 (children 17 and under have a \$25.00 co-payment for Optomap only). In certain cases the doctor may elect to dilate the eyes after viewing the images and scans to further assess any areas of concern.

DIABETIC patients who are not monitored yearly by other eye care professionals outside this office may require both a dilation as well as an OPTOMAP and iWellness Scan

- 2 ***Dilated Retinal Exam.*** After instilling drops in the eyes the pupils will enlarge after 20-30 minutes. This gives the doctor the ability to do a more complete assessment of the back of the eyes with the use of special lights and lenses. The drops will cause some blurriness and light sensitivity for approximately 3 hours. We will provide you with disposable sunglasses that will reduce the light sensitivity and allow you to drive and be outdoors.
- 3 You can elect to have neither the ***Dilation*** nor the ***Optomap Retinal Exam and iWellness Scan*** performed today. By selecting this option you are limiting the doctor's ability to early detect certain eye disease which can lead to future vision loss. The non-dilated retinal exam will provide only a partial and incomplete assessment of the health of the eyes.

I elect to have my eye health assessed by method # _____

Patient/Guardian Signature

Date