NAME OF THE HOSPITAL: _____ 1.

Photocoagulation for Retinopathy of Prematurity: S3B4.5

1. Name of the Procedure: Photocoagulation for Retinopathy of Prematurity

2. Indication: Type 1 Pre-threshold ROP

3. Does the patient presented with Type 1 Pre-threshold Retinopathy of Prematurity diagnosed on Fundus Examination: Yes/No (Upload Fundus Photograph/ Fundus Sketch)

4. If the answer to question 3 is Yes then is the patient having evidence of Media Opacities resulting in poor view of fundus: Yes/No

For eligibility for Photocoagulation for Retinopathy of Prematurity, the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

_____