

Genetics and Molecular Analysis of FEVR

PATIENT NAME: _____ MAIDEN NAME: _____

DOB (mm/dd/year): ____ / ____ / ____ PHONE: _____ ETHNICITY: _____

ADDRESS: _____

CITY: _____ State: _____ Zip Code: _____

Photographs: Fluoroscein Available: YES ___ NO ___ Color Fundus Available: YES ___ NO ___

VISION: OD ____ / ____ OS ____ / ____

Previous Photocoag Laser Tx: Date: _____ Eye (circle): OD, OS, OU

FEVR Diagnosed: YES ___ NO ___

Patient Diagnosis:

Notes:

Physician Signature: _____

Date: _____

FOR LAB USE ONLY

Consent Form Signed:

___ Yes

___ No

Family:

___ New

___ Existing

In-House DNA Extraction: YES ___ NO ___ Volume (µL) _____

Candidate for Gene Sequence: YES ___ NO ___

Plan: Genotyping

Blood

Normal Control

DNA

STR Marker

Swab

Age match Control

Cell line (lymphocytes)