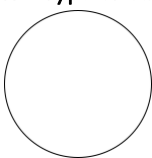
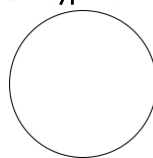


# PATIENT FORM – 521

**Patient Number** 521      **Gender** Females | ស្រី  
**Family Name** URK DANA      **Given Name/s:** {Given Name/s:  
 (KH/EN):6}  
**Age** 44      **Patient has TB:** No  
**Province** Prey Veng      **District:** Svay Antor  
**Village** N/A      **Commune:** N/A  
**Reason for visit** Eyes Blurry Distance | មើលឆ្ងាយព្រិល  
 Eyes Tearing (Both) | ហូរទឹកភ្នែកសងខាង  
 Eyes Pain/Discomfort (Both) | ឈឺភ្នែក  
**Mobile Number** 068578427

R L

## PRE-SCREENING

|                                                                                    |    |               |    |                                                                                     |    |                 |    |    |
|------------------------------------------------------------------------------------|----|---------------|----|-------------------------------------------------------------------------------------|----|-----------------|----|----|
| <b>UNAIDED / AIDED VA</b>                                                          |    | RE 6/         |    | LE 6/                                                                               |    |                 |    |    |
| <b>PINHOLE VA</b>                                                                  |    | RE 6/         |    | LE 6/                                                                               |    |                 |    |    |
|                                                                                    | RE | LE            | RE | LE                                                                                  | RE | LE              | RE | LE |
| IOP                                                                                |    |               |    |                                                                                     |    |                 |    |    |
| TIME                                                                               |    |               |    |                                                                                     |    |                 |    |    |
| <b>ANTI-GLAUCOMA TX</b>                                                            |    | <b>DIAMOX</b> |    | <b>ALPHAGAN</b>                                                                     |    | <b>COMBIGAN</b> |    |    |
| <b>AUTO-Ks</b>                                                                     |    | RE 6/         |    | LE 6/                                                                               |    |                 |    |    |
| <b>AUTO Rx</b>                                                                     |    | RE 6/         |    | LE 6/                                                                               |    |                 |    |    |
| <b>R – Type of Cataract</b>                                                        |    |               |    | <b>L – Type of Cataract</b>                                                         |    |                 |    |    |
|  |    |               |    |  |    |                 |    |    |
| R Posterior                                                                        |    |               |    | L Posterior                                                                         |    |                 |    |    |
| <input type="checkbox"/> R CATARACT EXTRACTION                                     |    |               |    | <input type="checkbox"/> L CATARACT EXTRACTION                                      |    |                 |    |    |
| <input type="checkbox"/> R PTERYGIUM                                               |    |               |    | <input type="checkbox"/> L PTERYGIUM                                                |    |                 |    |    |
| <input type="checkbox"/> R TRACHOMA REPAIR                                         |    |               |    | <input type="checkbox"/> L TRACHOMA REPAIR                                          |    |                 |    |    |
| <input type="checkbox"/> R OTHER SURGERY                                           |    |               |    | <input type="checkbox"/> L OTHER SURGERY                                            |    |                 |    |    |
| Optomo Initials                                                                    |    |               |    |                                                                                     |    |                 |    |    |

## REFRACTION

|                                            |       |                                                                  |       |       |
|--------------------------------------------|-------|------------------------------------------------------------------|-------|-------|
| <b>SUBJ Rx</b>                             | RE 6/ | Add +                                                            | LE 6/ | Add + |
| <input type="checkbox"/> GLASSES DISPENSED |       | <input type="checkbox"/> PRESCRIPTION GIVEN FOR UPDATE ELSEWHERE |       |       |

Other Comments:



# PATIENT FORM – 521

## Medical History

|                               |  |                 |            |                     |  |
|-------------------------------|--|-----------------|------------|---------------------|--|
| Heart Disease including       |  |                 |            |                     |  |
| Chest Pain                    |  | Hypertension    |            | Shortness of breath |  |
| Respiratory History including |  |                 |            |                     |  |
| Asthma                        |  | Cough           |            | COPD                |  |
| Metabolic History including   |  |                 |            |                     |  |
| Diabetes                      |  | Thyroid Disease |            | Kidney Failure      |  |
| Infections including          |  |                 |            |                     |  |
| Skin                          |  | HIV             |            | Hepatitis           |  |
| Additional History            |  |                 |            |                     |  |
| Medications                   |  |                 | Operations |                     |  |
| Mental Health                 |  |                 | Allergies  |                     |  |

## Tests

|               |  |             |  |                 |  |
|---------------|--|-------------|--|-----------------|--|
| O2 Saturation |  | Temperature |  | Fasting Glucose |  |
| BP            |  | Pulse Rate  |  | Heart Sound     |  |
| Other tests:  |  |             |  |                 |  |
| CXR           |  | E.C.G.      |  | Blood test      |  |

## Clinical Examination

|                       |  |             |  |                  |  |
|-----------------------|--|-------------|--|------------------|--|
| CVS                   |  | Respiratory |  | Anaemic/Jaundice |  |
| Medications Dispensed |  |             |  |                  |  |

## Surgery Status

|                                  |  |                            |  |
|----------------------------------|--|----------------------------|--|
| Can lay down for an hour         |  | Is patient fit for surgery |  |
| Patient needs to be reviewed for |  |                            |  |

## Consent to Eye Examination – Treatment – Surgery

Patient, Parent or Guardian was asked in the Khmer language if they agree/consent to examination and treatment of their eyes, or child's eyes, including placing of drops in to the eye and surgery if required, by the Cambodia Vision Ophthalmic Team. And in witness thereof Patient's or Guardian's signature or Mark/Thumb Print. All information is based on the persons Cambodian National Identity Card, where available, or oral enquiry of the person by the Cambodian registration team member.

Patient, Parent, or Guardian AGREES/CONSENTS to all of the above, Signed on 20/10/2024