

Site No.:

Patient Initials:

Investigator No.:

Patient No.:

Protocol: IMT- 002 - LTM

Date of Exam: M D Y

Operative Eye: OD OS

ALL ITEMS MUST BE COMPLETED. MISSING OR INCORRECTLY COMPLETED ITEMS WILL REQUIRE ADDITIONAL FOLLOW-UP.

ADVERSE EVENT FORM

Page 1 of 2

1. Date of Adverse Event Onset: M D Y

2. Eye Affected: OD OS OU

3. Adverse Events: Yes No

- | | |
|--|--|
| <input type="checkbox"/> Anterior chamber inflammation | <input type="checkbox"/> Iridotomy |
| <input type="checkbox"/> Choroidal detachment | <input type="checkbox"/> Iris atrophy |
| <input type="checkbox"/> Choroidal hemorrhage | <input type="checkbox"/> Iris damage |
| <input type="checkbox"/> Choroidal neovascularization | <input type="checkbox"/> Iris prolapse |
| <input type="checkbox"/> Corneal decompensation | <input type="checkbox"/> Iritis |
| <input type="checkbox"/> Corneal edema | <input type="checkbox"/> Iris transillumination defect |
| <input type="checkbox"/> Corneal transplant | <input type="checkbox"/> Optic atrophy |
| <input type="checkbox"/> Cyclitic membrane | <input type="checkbox"/> Precipitates or deposits on IMT |
| <input type="checkbox"/> Diplopia | <input type="checkbox"/> Pupillary block |
| <input type="checkbox"/> Distorted pupil | <input type="checkbox"/> Retinal detachment |
| <input type="checkbox"/> Endophthalmitis | <input type="checkbox"/> Retinal vascular occlusion |
| <input type="checkbox"/> Flat anterior chamber | <input type="checkbox"/> Subretinal hemorrhage |
| <input type="checkbox"/> Hyphema | <input type="checkbox"/> Synchiae ___ AS ___ PS _____ of clock hours |
| <input type="checkbox"/> Hypotony | <input type="checkbox"/> Treatment of PCO (Nd:YAG, Needling) |
| <input type="checkbox"/> Hypopyon | <input type="checkbox"/> Uveitis/Vitritis |
| <input type="checkbox"/> IMT dislocation | <input type="checkbox"/> Vitrectomy/vitreous aspiration |
| <input type="checkbox"/> IMT repositioning | <input type="checkbox"/> Vitreous hemorrhage |
| <input type="checkbox"/> IMT removal | <input type="checkbox"/> Vitreous in anterior chamber |
| <input type="checkbox"/> Increased IOP requiring treatment | <input type="checkbox"/> Zonular dehiscence |
| <input type="checkbox"/> Secondary Surgical Intervention | <input type="checkbox"/> Other 1: Specify _____ |
| <input type="checkbox"/> Other 2: Specify _____ | <input type="checkbox"/> Other 3: Specify _____ |

5. Severity of Adverse Event at Follow-up: (check one)

1 Mild 2 Moderate 3 Severe

6. Additional Treatment of Adverse Event: (describe all)

	Yes	No
Surgical	<input type="checkbox"/>	<input type="checkbox"/>
Medical	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, specify: _____

If Yes, specify: _____

7. Prognosis: (check one)

1 Excellent 2 Good 3 Fair 4 Poor

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8. Outcome: *(current status of patient)*

- Event resolved with no sequelae *(Date of Resolution)*: M
- Event resolved with sequelae *(Date of Resolution)*: M
- Event unresolved *(If event unresolved, complete AR Follow-up Form)*

9. Relationship of adverse event to IMT, in the opinion of the investigator:

- Not related Unlikely to be related Possibly related Probably related Definitely related

Investigator's Signature: _____

Date: _____