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CONFIRMATION OF DIAGNOSIS

To be completed by the eye specialist – PLEASE PRINT CLEARLY

Name of Patient: ______

Date of Birth: Y Y Y Y - M M - D D **Tel/Cell** ______ **Email** ______

Address: ______

Gender: | M | F | **Ethnic Group** | Asian | Black | Coloured | Indian | White |

In my opinion the patient has one of the following conditions:

RETINITIS PIGMENTOSA	Diffuse Form	
	Sectoral (regional) form	
USHER SYNDROME	Type I – profound deafness	
(RP & congenital hearing loss)	Type II – severe deafness	
MACULAR DEGENERATION	Age-related MD - Wet	
	- Dry	
	Best Disease	
	Cone & Rod Dystrophy	
	Sorsby Fundus Dystrophy	
	Pattern Dystrophy	
	Stargardt Disease	
	Fundus Flavimaculatus	

Other retinal disorder (specify): ______

MODE OF INHERITANCE

Dominant ☐ **Recessive** ☐ **X-Linked** ☐ **Isolated Case** ☐ **Unknown but familial** ☐

Age of Onset: ______ **years**

Progression of disease: ______

Other clinical features: ______

Tests performed: **ERG/EOG** ☐ **Visual Acuity** ☐ **Kinetic Visual Fields** ☐ **OCT** ☐

Fluorescein Angiogram ☐ **Colour Fundus Photographs** ☐

Other family members affected: ______

Name of Doctor: ______ **Signature:** ______

Date: Y Y Y Y – M M – D D **Tel.** ( ) **Email** ______

PLEASE RETURN THE COMPLETED FORM TO: retina@uct.ac.za