CentrSight IMT - Am I Suitable?

Please fill out as much of this questionnaire as you can.

CENTRE FOR SIGHT

Name .....

Address .....

.....

.....

.....

Postcode .....

E-mail .....

Phone number .....

Q1. Macular Degeneration

Do you have Macular Degeneration? YES / NO

If YES, do you have Macular degeneration in both eyes? YES / NO

Q2. Previous Treatment

YES / NO

Have you had laser treatment or drug injections inside your eye specifically to treat your macular degeneration?

CentrSight IMT - Am I Suitable

CENTRE FOR SIGHT

Q3. Previous treatment continued.

If yes to Q2, does it affect your ability to read? YES / NO

Does macular degeneration affect your central vision? YES / NO

Q4. Please answer the following -

Are you registered as blind? YES / NO

Does your vision allow you to drive? YES / NO

Do you have difficulty recognising people due to your vision? YES / NO

Q5. Cataract Surgery

Have you had Cataract surgery? YES / NO

If you need any assistance filling in this form please call **0800 011 2887**

Return this questionaire to -

Centre for Sight, Hazelden Place, Turners Hills Road
West Sussex, RH19 4RH