LCIF/Sight First Grant

LIONS DIABETES AWARENESS FOUNDATION OF MD-35

Florida Lions Diabetic Retinopathy Foundation

Screening Consent Form

Administrative Use Only
Participant ID Code: _____

Please Print Clearly. Please complete the entire form (front and back).

Date: ___/___/___ Participant Name: _____

Date of Birth: ___/___/___ Phone Number: (____)_____

Email Address: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ @ __ __ __ __ __ __ __ __ . __ __ __

Mailing Address : _____ City: _____

Zip:_____ County: _____

Please read the following carefully. If you have any questions, please ask!

The purpose of this screening is to identify individuals with abnormal blood sugar levels and individuals with eye conditions that may require examination by an eye doctor. This screening does not provide a diagnosis. **Only participants who are diabetic or have an abnormal blood sugar reading will receive a retinal screening.** All images will be reviewed by a retinal specialist (a doctor who specializes in examining the back of the eye). A small percentage of participants will not be able to be screened because of small pupils or other conditions which limit the camera's ability to view the retina. If this occurs you will be referred for an eye examination that may require eye drops for dilation.

You will be contacted with the results of your screening and a recommendation whether you should follow up with a medical provider and/or eye doctor and when you should be screened again.

You are granting the Lions Diabetes Awareness Foundation of MD-35 the use of the information from your Health Risk Assessment, evaluation, follow-up, referrals, and use of de-identified images or other information for educational and statistical purposes. You also authorize us to share results and recommendations with your medical provider. None of your information will be sold or given to any agency. All requested information is for statistical purposes and is strictly confidential.

By participating in this screening, you hereby agree to assume all risk of injury to yourself. You also understand that your Health Risk Assessment is intended for educational purposes only and does not replace the care and advice of a medical provider.

I agree to the above and would like to complete the Health Risk Assessment and participate in this screening.

Signature _____ Date: ___/___/___ Witness: _____

Guardian must sign if the participant is under 18 years old or is not an emancipated minor.

I give consent to a glucose screening by the Lions club. _____

Screening Location: _____ Name _____

Witness _____ Date _____

Health Risk Assessment

☐Male ☐ Female **Age** ☐0-10 ☐11-18 ☐19-40 ☐41-60 ☐60+

Are you pregnant? ☐Yes ☐No

Race ☐White ☐Black ☐Asian or Pacific Islander ☐American Indian or Alaskan Native

☐Multiracial ☐ Indian ☐Hispanic Origin ☐ Other _____

Do you have

Diabetes Mellitus: ☐Type 1 ☐Type 2 ☐Gestational ☐Pre-diabetes

Duration of Diabetes (in years): ____

Current Diabetes Therapy: ☐Insulin ☐Oral Hypoglycemic ☐Diet Control ☐None

HbA1C:____% ☐<6 months ☐>6 months ☐Unknown

Participant reports diabetes is under control? ☐Yes ☐No

Do you have High Blood Pressure? ☐Yes ☐No

Do you have a family history of:

Diabetes? ☐Yes ☐No **High Blood Pressure?** ☐Yes ☐No **Eye Disease?** ☐Yes ☐No

Your Last exam by an Eye Doctor: ___/___/___ by Dr. _____

☐ Participant has never had an eye exam

Have you ever been diagnosed with: ☐Glaucoma ☐Macular Degeneration ☐Cataracts

What eye problems are you currently being treated for?_____o

you have Medical Insurance, including Medicare or Medicaid?

☐No ☐Yes (list all) _____

Screening Results – Administrative Use Only

Blood Sugar Screening

It has been about ☐1 hr ☐2 hrs ☐3+ hrs since I last ate food and/or drank a beverage with sugar.

RESULTS	NORMAL VALUE	REFERRED?
_____	1 Hour (90-150 mg/dl)	_____
_____	2 Hours (60-110 mg/dl)	_____
_____	3 Hours (70-100 mg/dl)	_____

Visual Acuity (Pass/Fail) **Right: P / F** **Left: P / F**

Blood Sugar Screener _____ Retina Screener _____

Comments:_____

_____