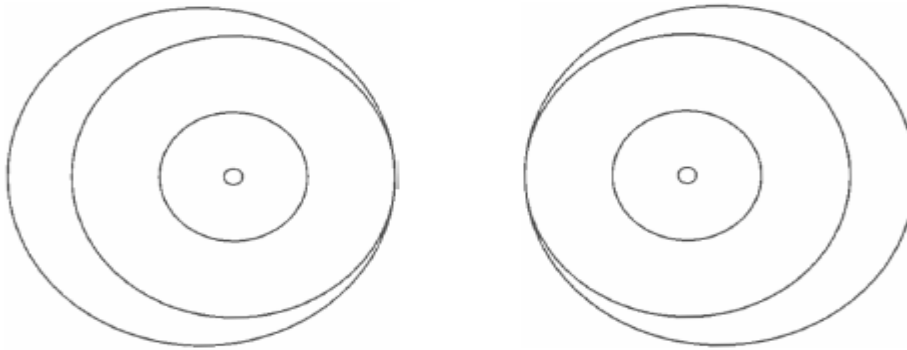


# Retinopathy of Prematurity Chart

Full Name: .....  
 Address: **Addressograph** .....  
 HCR: .....  
 HCR No: ..... DOB: \_\_\_ / \_\_\_ /

<b>Gestational Age</b>		<b>Birth Weight</b>	
<b>Corrected Age</b>		<b>Date of Examination</b>	

MEDICATIONS	MEDICATIONS



<i>Please tick</i>		OD	OS	ASSESSMENT
1	<b>Immature</b>			
2	<b>Mature</b>			
3	<b>Zone</b>			
4	<b>Stage</b>			
5	<b>Plus disease</b>			
1	<b>Retinal Vascular Dilation</b>			
2	<b>Iris vessel dilation</b>			
3	<b>Vitreous Dilation</b>			
4	<b>Retinal Haemorrhage</b>			
5	<b>Pupil Rigidity</b>			

**Date of Next Examination:**

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**Consultant Name / Stamp:** .....