|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **Identificação do Médico Assistente:** | |  | | |  |
| **Nome:** | | **CRM:** | | | **Telefone:** |
| 1. **Termo de Responsabilidade** 2. Declaro que sou responsável pela supervisão deste tratamento e prestarei ao beneficiário, à vigilância sanitária e à equipe envolvida na administração do medicamento as informações médicas que se fizerem necessárias. 3. Em conformidade com a Resolução CFM 1614/2001, autorizo os auditores médicos da Unimed Londrina a consultarem o prontuário médico mantido no meu serviço, para informações complementares, desde que haja autorização prévia emitida pelo Diretor Técnico da Unidade. 4. Em situações excepcionais o beneficiário poderá ser contatado para maiores esclarecimentos estando, inclusive, sujeito a exame pericial. | | | | | |
| 1. **Identificação do Paciente:** | | | | | |
| **Nome:** | | | | **Código Identificador:** | |
| **Data de Nascimento:** | **Sexo:** | | **Telefone:** | | |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 1. **Critérios de Inclusão** | | | | | | | | | | | 1. **Oclusão de Veia Central da Retina (OVCR)**   Isquêmica  Não isquêmica (Retinopatia de estase venosa) | | | | | | | | | | | 1. **Oclusão de Ramo de Veia Central da Retina (ORVCR)**   Olho a ser tratado:  Olho direito  Olho esquerdo | | | | | | | | | | | 1. **Achados clínicos:** | | |  | | |  | | | | | Dilatação venosa | | Hemorragia retiniana | | | Exsudatos algodonosos | | | Edema macular | | | Edema papilar | | | Neovascularização Retina | | | Neovascularização de disco óptico | | | | | 1. **Angiofluoresceinografia (AGF):** | | | | | | | | | | | Edema macular | Áreas de hipoperfusão | | | Neovascularização de disco | | | Neovascularização Retina | | | | 1. **Tomografia de Coerência Óptica (OCT):** | | | | | | | | | | | Edema macular | | | | | Membrana epirretiniana (MER) | | | | | | 1. **Acuidade Visual Pré Tratamento (Snellen)** | | | | | | | | | | | **OLHO DIREITO** | | AV/CC= | | | **OLHO ESQUERDO** | | | | AV/CC= | | 1. **Achados no(s) Exame(s) – Campo destinado a observações adicionais:** | | | | | | | | | | | AA partir da 4ª (quarta) aplicação com a mesma droga, será necessário envio apenas do RELATÓRIO DE CONTINUIDADE DE TRATAMENTO. | | | | | | | | | | | **TRATAMENTO PROPOSTO**  **LUCENTIS® (RANIBIZUMABE)**  **EYLEA® (AFLIBERCEPT)** | | | | | | | | | | | **Trata-se de mudança de medicamento?**  Sim  Não | | | | | | | | | | | **Justificativa para mudança da droga:** | | | | | | | | | | | Caso se opte por marcar SIM para mudança de medicamento OU tratamento antiangiogênico anterior com a mesma droga, informar quantidade de aplicações prévias de antiangiogênicos e datas em que as mesmas ocorreram (por órgão acometido): | | | | | | | | | | | **OLHO DIREITO** | | | | | **OLHO ESQUERDO** | | | | | | Sem doses prévias de antiangiogênicos | | | | | Sem doses prévias de antiangiogênicos | | | | | | Com doses prévias de antiangiogênicos | | | | | Com doses prévias de antiangiogênicos | | | | | | 1ª aplicação - Data: \_\_/\_\_/\_\_\_\_ | | | | | 1ª aplicação - Data: \_\_/\_\_/\_\_\_\_ | | | | | | 2ª aplicação - Data: \_\_/\_\_/\_\_\_\_ | | | | | 2ª aplicação - Data: \_\_/\_\_/\_\_\_\_ | | | | | | | | | | | |

|  |  |
| --- | --- |
| Data: **/     /** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assinatura e carimbo do Médico Assistente |