|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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. **Diagnóstico**   **Degeneração Macular Relacionada à Idade:** | | | | | | | | | | | | | | | | | Forma Exsudativa: | Olho direito | | | Olho esquerdo | | | | | Ambos os olhos | | | | | Não apresenta | | | Cicatriz Disciforme: | Olho direito | | | Olho esquerdo | | | | | Ambos os olhos | | | | | Não apresenta | | | **Membrana Neovascular Ativa:**  Sim  Não | | | | | | | | | | | | | | | | | Se sim, indique os achados: | | | | | | | | | | | | | | | | | 1. Mapeamento de Retina: | | | Fluido sub-retinado | | Hemorragia | | | | | Fibrose sub-retiniana | | | | | DEP | | 1. Angiografia Fluoresceínica (AGF): | | | Presença de vazamento de contraste em áreas suspeitas | | | | | | | | | | | | | | 1. Tomografia de Coêrencia Óptica (OCT): | | | Fluido sub-retiniano | | | | | Fluido intra-retiniano | | | | | DEP | | | | 1. Angiografia c/ Indocianina Verde (ICG): | | | Não realizada | | | | | | | Realizada | | | | | | | Achados da ICG: | | | | | | | | | | | | | | | | | **Metamorfopsia:** | | | | | | Sim  Não | | | | | | | | | | | **BAV:** | | | | | | Sim  Não | | | | | | | | | | | 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:** | | | | | | | | | | | | | | | | | Achados complementares de Mapeamento de Retina (MR), Angiografia Fluoresceínica (AFG), Angiografia com Indocianina Verde e/ ou Tomografia de Coerência Óptica. | | | | | | | | | | | | | | | | | Encaminhar laudos e imagens impressas ou em CD/DVD dos exames realizados.  A 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 troca 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 |