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| 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:** | | |
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mácula (EMD):** | | | | | | | | | | | | | | Leve | | | Moderado | | | | | Grave | | | | | | 1. **Angiografia fluoresceínica (AGF):** | | | | | | | | | | | | | | Extravasamento tardio (EMD) | | Isquemia macular | | | Neovascularização | | | | | | Hemorragia | | | 1. **Tomografia de Coerência Óptica:** | | | | | | | | | | | | | | Fluido subfoveal | Alterações císticas | | | MER | | | | | Tração vítreo-macular (TVM) | | | | | **Oclusão Vascular:**  Olho direito  Olho esquerdo  Ambos os Olhos | | | | | | | | | | | | | | Aguda | | | | Crônica Obs: se crônica, mencionar tempo de instalação: | | | | | | | | | | 1. **Edema de mácula:**  Sim  Não 2. **Angiografia fluoresceínica (AGF):**   Área(s) de hipoperfusão  Neovascularização (retina ou D.O)  Hemorragia Retiniana   1. **Tomografia de Coerência Óptica:** | | | | | | | | | | | | | | Edema macular | Cistos (retina externa) | | | Edema Retiniano Difuso | | | | | | FSR | | | | 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:** | | | | | | | | | | | | | | Encaminhar laudos e imagens dos exames realizados por meio eletrônico ou em CD/DVD | | | | | | | | | | | | | | 1. **Históricos de eventos prévios** 2. **Pseudofácico:**   Olho direito  Olho esquerdo  Não | | | | | | | | | | | | | | Se SIM, mensurar data(s) da(s) Facectomia(s) - especificar por olho: | | | | | | | OD: \_\_/\_\_/\_\_\_\_ | | | | | OE: \_\_/\_\_/\_\_\_\_ | | Se PSEUDOFÁCICO, apontar se rotura de cápsula no transoperatório: | | | | | | | Sim | | | | | Não | | 1. **Laserterapia:**   Sim  Não | | | | | | | | | | | | | | Se SIM, mensurar olho tratado, número de sessões, datas prévias das mesmas (por órgão acometido). | | | | | | | | | | | | | | 1. **Vitrectomia via pars plana:**  Olho direito  Olho esquerdo  Não | | | | | | | | | | | | | | Se SIM, descrever data(s) prévia(s) em que o(s) eventos ocorreu(ram) (por órgão acometido). | | | | | | OD: \_\_/\_\_/\_\_\_\_ | | | | | | OE: \_\_/\_\_/\_\_\_\_ | | 1. **Antiangiogênicos:**  Olho direito  Olho esquerdo  Não | | | | | | | | | | | | | | Se SIM, especificar número de aplicações prévias e data da última aplicação (por órgão acometido). | | | | | | | | | | | | | | Se NÃO, justificar o motivo pelo qual esta classe de drogas foi preterida no presente caso. | | | | | | | | | | | | | | Obs.: a autorização de cada aplicação será vinculada ao envio de guia à Unimed, acompanhada do Relatório padrão adequadamente preenchido | | | | | | | | | | | | | | 1. **Olho a ser tratado (OZURDEX®)**   Olho direito  Olho esquerdo | | | | | | | | | | | | | | **Trata-se da primeira aplicação?**  Sim  Não  Caso se opte por marcar NÃO, informar olho que foi tratado, quantidade de eventos prévios de implante intravítreo de Ozurdex® e datas em que os mesmos ocorreram (por órgão acometido): | | | | | | | | | | | | | | | | | | | |

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