

**Genetics and Molecular Analysis of Human Vision**

PATIENT NAME: \_\_\_\_\_ MAIDEN NAME: \_\_\_\_\_

DOB (mm/dd/year): \_\_\_ / \_\_\_ / \_\_\_ PHONE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Photographs: Fluorescein Available: YES \_\_\_ NO \_\_\_ Color Fundus Available: YES \_\_\_ NO \_\_\_

VISON: OD \_\_\_ / \_\_\_ OS \_\_\_ / \_\_\_

Previous Photocoag Laser Tx: Date: \_\_\_\_\_ Eye (circle): OD, OS, OU

Disease Diagnosed (circle): FEVR Macular Degeneration RP Glaucoma Strabismus  
Patient Diagnosis:

Notes:

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR LAB USE ONLY**

Consent Form Signed:

Yes

No

Family:

New

Existing

In-House DNA Extraction: YES \_\_\_ NO \_\_\_ Volume (µL) \_\_\_\_\_

Candidate for Gene Sequence: YES \_\_\_ NO \_\_\_

**Plan:** Genotyping

Blood

Normal Control

DNA

STR Marker

Swab

Age match Control

Cell line (lymphocytes)