SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

ROP SCREENING CONSENT

Name_____(MRN NO._____)

I hereby give consent for the eye examination of my child for the Retinopathy of Prematurity (ROP) screening suspected retinal abnormality. This examination of retina is done by a trained technician using a digital camera or by an Ophthalmologist using special instrument. The doctors have explained to me about the condition (ROP) which can occur since my baby was born premature with low birth weight. The doctors have explained me the necessity of the test and also told me that the examination may have to be done repeatedly depending upon the progression of the condition.

It has been explained to me the test involves dilation of the pupils with the help of eye drops 30-45 minutes before the retina examination. The doctor has explained me regarding the possible side-effects of the eye drops. It has been explained to me about eye examination complication such as breathing / heart rate abnormalities which in will subside. I also hereby give consent to use retina images / data of my child for quality monitoring training / research purposes. It has been explained that my child's identity will be kept confidential at all times.

वर लिहिलेले मला समजणाऱ्या भाषेत व्यवस्थित समजावून सांगितले आहे व मला प्रश्न विचारण्याची संधी होती .माझ्या सर्व शंकांचे निरसन झालेले असून मी सदर तपासणीस माझी संमती विचारपूर्वक देत आहे.

No/ अ.न	Person / संबंधित व्यक्ती	Name/ नाव	Sign/सही	Thumb/ अंगठ्याच्या ठसा
1	Patient's relative/ रुग्णाचा नातेवाईक व नाते			
2	Doctor /वैद्यकीय अधिकारी			
3	Interpreter /अनुवादक			