



PUPIL DILATION AND RETINAL IMAGING

As part of the comprehensive eye exam, pupil dilation allows Dr. Yoakum to examine the back of the eye, or the retina. This is very important to screen for, or follow, such conditions as macular degeneration, diabetes, glaucoma and other retinal diseases. It also provides the most accurate investigation into your ocular health and many important aspects of your general health. Dilation is done by putting drops in the eyes and waiting 15 to 30 minutes for the pupils to become enlarged. The drops can cause sensitivity to light as well as trouble focusing on close objects. Your eyes may stay dilated from 2 to 6 hours, however some patients may stay dilated longer. **There is no additional charge for the dilation and can be rescheduled for patients who would like to do it at a more convenient time.**

Also as part of the comprehensive exam, retinal images can be taken to document the health and condition of your eyes at the present time. Retinal images are obtained by using a highly sophisticated digital camera to take a high resolution image of the macula, optic nerve head, and surrounding fundus. This image can be used to zoom in on areas of the retina that need further evaluation and can be compared year to year to document any changes or developing conditions. Retinal images can be taken on dilated and un-dilated eyes. Photo documentation of the retina is strongly recommended for patients with a retinal condition but is optional for patients when performed as preventative care. **For patients that have a retinal disease, insurance can, in some cases, be filed for this procedure. For all other patients the fee for the retinal photos is \$35.00.**

Please indicate your preference for the pupil dilation:

- I accept dilation today.
- I decline dilation for today but would like to reschedule for another day.
- I do not wish to be dilated this year and will not hold Heritage Eye Care liable for any missed diagnosis or treatment that would otherwise be followed as a consequence of this procedure.

Please indicate your preference for the retinal photos:

- I wish to have retinal photographs taken.
- I do not wish to have retinal photographs taken.

Signature of Patient or Guardian

Date