

Dilation/Optomap® Consent Form



At Happy Valley Vision Source we pride ourselves on providing our patients with the highest standard of care. Because of this, we now perform the **Optomap® Retinal Imaging** on ALL patients.

Our doctors believe **Optomap® Retinal Imaging** is an essential part of your comprehensive exam and prescribe it for all patients at every annual exam.

This non-invasive technology allows our doctors to see a high resolution, ultra-wide image of the inside of your eye, **without the need to dilate your pupils** in most cases*. Optomap® Retinal Imaging aids in early detection of eye diseases including glaucoma, macular degeneration, retinal detachment, and diabetic retinopathy, as well as risk for systemic conditions such as hypertension, diabetes, cancer, and stroke. Without the Optomap® Retinal Imaging and/or dilated exam, the doctor only sees ~30% of the internal part of the eye.

There is a \$39 fee for the OPTOMAP® RETINAL IMAGING which is NOT COVERED BY INSURANCE unless being used to actively follow a medical disease.

Optomap® Retinal Image	Pupil Dilation
No eye drops required	Eye drops required
No blurred vision	Blurred vision for 4-6 hours
No light sensitivity	Light sensitivity for 4-6 hours
Takes 2 minutes to capture images	Takes 15-30 minutes for drops to take effect
~80% of retina viewed	~90-100% of retina viewed
Retinal images will be viewed by you and the doctor, and saved to your permanent medical file for year-to-year comparison	Only the doctor can view the retina

*Many patients who choose to have the **Optomap® Retinal Image** will not require pupil dilation, however your doctor will determine if dilation is necessary based on your specific conditions or concerns. Some patients with specific conditions will require a higher fee level **Medical Optomap® Retinal Image** that may be partially or fully covered through your medical insurance.

If you elect not to accept the prescribed OPTOMAP® RETINAL IMAGING, **you will be required to dilate your pupils at your exam.**

I elect to OPT OUT of Optomap® Retinal Imaging. I elect PUPIL DILATION DROPS instead. I understand that driving is NOT recommended after this procedure for 4-6 hours due to the side effects of blurry vision and light sensitivity. I will bring a driver. I accept full responsibility for any activities I perform after dilation.

By signing below, I acknowledge that I have read, understood, and agree to the Dilation/Optomap® Consent Form.

Patient/Guardian Signature: _____ **Date:** _____

Patient Name: _____