UNIVERSITY OF VIRGINIA HEALTH SYSTEM

0400002

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

PROTECT YOUR BABY'S EYESIGHT
RETINOPATHY OF PREMATURITY CAN CAUSE BLINDNESS
FOLLOW THESE IMPORTANT INSTRUCTIONS!

TO THE PARENTS OF _____ **DATE** _____

Your baby is being discharged from the hospital and requires examinations for **Retinopathy of Prematurity (ROP)**. An appointment has been made for an out-patient ROP examination for your child with a local ophthalmologist (eye doctor) specializing in this condition. This may be your baby's first examination or a follow-up examination from inpatient ROP screening.

It is very important for you to keep this appointment. ROP is a potentially blinding disease, and there is no way for you to know if your child is developing mild or severe disease unless the eyes are examined by an ophthalmologist. The ophthalmologist will continue to examine your baby's eyes every 1 to 4 weeks until the retinal blood vessels are fully mature. This usually occurs within a month or two of your baby's "due date" or later in some babies.

ROP EYE DOCTOR APPOINTMENT: **DATE** _____

TIME _____

WHO/WHERE:

☐ **Dr. Christian Carter**
1101 E Jefferson St #3
Charlottesville, VA 22902
Phone: 434-295-5193

☐ _____
_____
_____
Phone: _____

Please tell your nurse prior to hospital discharge if you cannot go to the eye doctor. An ROP examination must be performed by a pediatric ophthalmologist or an ophthalmologist experienced in ROP examinations in your area within a few days of this scheduled appointment.
MISSING THIS APPOINTMENT CAN RESULT IN BLINDNESS FOR YOUR BABY!
Please call the ophthalmologist's office immediately if there are any problems.

I have read the above. It has been clearly explained. I understand that ROP is a potentially blinding eye condition that requires follow-up examinations exactly as scheduled. All of my questions have been answered.

_____ _____
Signature of Parent or Guardian **Date**

Reviewed By: _____ _____
Printed Name **PIC**

_____ _____
Staff Name/Signature/Title **Date**

(For patients who do not speak English or Spanish)

This information was interpreted by _____
Name or Cyracom #

PO Box 801430 I Charlottesville, VA 22908-0800 I 434.924.2335 I Fax 434.982.0796