Optomap®

Retinal Exam

We all want to protect our gift of sight. That is why it is important to have annual eye health examinations. Annual check-ups not only allow Dr. Mulqueeny to improve the quality of your vision, but it also provides the opportunity to determine the overall health of your eye –from the clear window of the eye (cornea) to the very back (retina).

Dr. Mulqueeny highly recommends that you have an Optomap® Retinal Exam, a comprehensive method of evaluating, monitoring, and helping treat various eye conditions. Another benefit to consider –this technology allows you to have your annual eye health exam without having your eyes dilated.

The Optomap® takes just minutes to perform and retinal analysis is an essential part of your annual eye exam. If you choose the advanced technology of Optomap® instead of dilation, the cost to you is $50.00. Depending on your eye health history, the doctor may be able to submit to your insurance company; however, you will be responsible for any deductible and/or co-pay.

I understand the above and choose to:

☐ **Accept test** ***some circumstances require medical necessary dilation.**

☐ **Decline test** ***If you decline this test, you will be dilated.***

QuantifEye® MPOD Test

Age Related Macular Degeneration Risk Factors

Age-Related Macular Degeneration (AMD) is the leading cause of vision loss in adults. Its effect may be permanent and irreversible. Dr. Mulqueeny strongly recommends the QuantifEye® macular pigment optical density (MPOD) measurement to determine the density of the pigment in your macula. This information will allow him to assess your risk of AMD in the future. This measurement is not covered by insurance, the cost to you is $20.00 and there is a discount if you choose to pay out of pocket for the Optomap® as well.

AMD Risk Factors (please check all that apply)

☐ Age (over 50)
☐ Low macular pigment
☐ Cardiovascular disease
☐ Caucasian
☐ Overweight
☐ Discomfort due to glare, night or day
☐ Difficulty seeing objects against their background (contrast sensitivity)
☐ Family history of macular degeneration
☐ Smoker (current or prior)
☐ Light colored eyes
☐ Female
☐ Night driving difficulty
☐ Sensitivity to bright lights

I understand the above and choose to:

☐ **Accept test**

☐ **Decline test** **Patient Signature** _____ **Date** _____