Utsav Eye Clinic

ROP Screening Indicator Sheet

S. No

Mother's Name : _____

Date of Examination : _____

Name of Hospital : _____

Hosp. OP No. : _____ Hosp. IP No: _____

Date of Birth : _____

Address : _____

Tel. & Fax No. _____

Age (Weeks) : Gestational _____ Postnatal _____

Postconceptional (Ges. Age + Postnatal) _____

Birth Weight : _____ gms

Multiple Birth (Single = 1, Twins = 2, Triplets = 3)

Maternal Risk Factors (Yes = 1, No = 2)

Antepartum Haemorrhage

Gestational Diabetes

Maternal Hypertension

Others If 1 then specify _____

Neonatal Risk Factors (Yes = 1, No = 2)

Oxygen Therapy If 1 then specify No. of days _____

Intraventicular Haemorrhage Steroids

RDS Vit E

Photo Therapy Hb % _____

Surfactant Therapy

Blood Transfusion

Proven Sepsis

Others If 1 then specify _____

APGAR Score : 1 min: 5 min : 10 min :