

**St. Louis Eye Clinic, Inc.**

135 W Adams, Suite 302  
Kirkwood, MO 63122  
Telephone (314) 821-2002  
Fax (314) 821-2330

9/\_\_/2007

Patient Name  
Address 1  
Address 2

Re: Treatment for Wet Macular Degeneration

Dear Sir/Madam,

We are following up our treatment of you to determine its effectiveness and to make sure you fully understand its nature. Our records show you were treated for Wet Macular Degeneration one or more times during 2005-2007 at the St. Louis Eye Clinic. You received treatment in the form of an injection into the eye to treat your Wet Macular Degeneration. The drugs available during this period of time to treat that condition by injection were Macugen (beginning 2005), Avastin (beginning late 2005) and Lucentis (beginning in the Fall of 2006). The purpose of injecting any one of those drugs into your eye is to reduce leakage from the blood vessels causing Wet Macular Degeneration and thereby stabilizing your vision.

We have reviewed the Clinic's medical records which show that you may have received \_\_\_\_ doses of Avastin at 2.5 mg in 0.1 ml/dose when you may have been advised and signed a consent form that you were to receive \_\_\_\_ doses of Macugen at 0.3mg in 0.09 ml /dose to treat your condition.

To assist in determining the effectiveness of the treatment, we would appreciate your completing the enclosed Questionnaire and mailing it back in the self-addressed stamped envelope provided. Please feel free to contact me at 314-821-2002 or Clinic administrative personnel at 314-352-9800 with any questions regarding this letter or the enclosed Questionnaire. If you do not mind, someone from the Clinic may contact you to follow-up your responses if we have questions.

Sincerely,

Krishnarao. V. Rednam, M.D

Enclosure  
cc: Medical Record

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We have reviewed the Clinic's medical records which show that you may have received \_\_\_ doses of Avastin at 2.5 mg in 0.1 ml/dose when you may have been advised and signed a consent form that you were to receive \_\_\_ doses of Macugen at 0.3mg in 0.09 ml/dose to treat your condition. It is also possible that with \_\_\_ doses of Macugen at 0.3mg in 0.09 ml/dose that 0.02 ml of Lucentis was added to enhance the effectiveness of the drugs. Because the addition of Lucentis to treatment with Macugen is an off-label use of those drugs, we are eager to determine its effectiveness.

To make that determination, we would appreciate your completing the enclosed Questionnaire and mailing it back in the self-addressed stamped envelope provided. Please feel free to contact me at 314-821-2002 or Clinic administrative personnel at 314-352-9800 with any questions regarding this letter or the enclosed Questionnaire. If you do not mind, someone from the Clinic may contact you to follow-up your responses if we have questions.

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We have reviewed the Clinic's medical records which show that you may have received \_\_\_\_\_ doses of Macugen at 0.3mg in 0.09 ml /dose with 0.02 ml of Lucentis added to enhance the effectiveness of the drugs. Because the addition of Lucentis to treatment with Macugen is an off-label use of those drugs, we are eager to determine its effectiveness.

To make that determination, we would appreciate your completing the enclosed Questionnaire and mailing it back in the self-addressed stamped envelope provided. Please feel free to contact me at 314-821-2002 or Clinic administrative personnel at 314-352-9800 with any questions regarding this letter or the enclosed Questionnaire. If you do not mind, someone from the Clinic may contact you to follow-up your responses if we have questions.

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Krishnarao. V. Rednam, M.D

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Enclosure  
cc: Medical Record

**St. Louis Eye Clinic**

135 W. Adams, Suite 302  
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Telephone (314) 821-2002  
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**Questionnaire**

1. Since you received your last injection please circle which of the following best describes your experience:

- A) Vision Improved
- B) No Change in Vision
- C) Vision is Worse
- D) Other - describe: \_\_\_\_\_

2. In connection with response to question 1 above, at any time did you experience any of the following usual side-effects (please circle all that apply):

- A) Extreme Redness
- B) Swelling
- C) Watery Eyes
- D) Gritty Sand Feeling
- E) No Side-Effects (skip to question 4 if there were no side-effects)
- F) Other unusual side-effects -- (e.g. painful loss of vision) describe: \_\_\_\_\_

3. In connection with response to question 2 above, did the side-effect go away?  
(please circle)      YES      NO

3.1 If yes, how long did the side-effects last? \_\_\_\_\_

3.2 Did you call the Clinic with concerns?    YES      NO

3.3 If yes, with whom did you speak? \_\_\_\_\_

3.4 Were your questions answered?    YES      NO

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4. In connection with response to question 1 above, did you experience unusual pain or have soreness associated with your last treatment more than previous injections?  
(please circle) YES NO

4.1 If yes, how long did it last? \_\_\_\_\_

4.2 Did you call the Clinic with concerns? YES NO

4.3 If yes, with whom did you speak? \_\_\_\_\_

4.4 Were your questions answered? YES NO

5. Do you have any present concerns, issues or questions about your treatment or condition?

YES NO

6. Do you understand that you can call the Clinic at 314-821-2002 any time with questions or concerns?

YES NO

7. Would you like to schedule a follow-up examination or telephone conference with Dr. Rednam?

YES NO

IF YES, please describe reasons or problems \_\_\_\_\_

\_\_\_\_\_  
Please sign and date this Questionnaire and return to the St. Louis Eye Clinic in the self-addressed stamped envelope provided. You may also call the Clinic at 314-821-2002 for assistance in completing the Questionnaire.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**OFFICE USE ONLY**

Date Received: \_\_\_\_\_ Received by: \_\_\_\_\_

Date Contacted by Phone: \_\_\_\_\_ Contacted by: \_\_\_\_\_

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