Case Report Form:

Occurrence and outcome of ocular firework injuries in Switzerland

Instruction for answering the Case Report Form:

1. **Only one choice →** O
2. **Multiple choice →** ☐

Hospital_1	**Consecutive Number** Abbreviation XXX	**Date** DD.MM.YYYY

Demographic Data

Age at time point of injury XX years
(In case of < 1 year: XX months)

Gender
O Male O Female

Date of injury DD.MM.YYYY O Unknown O Others: ___________
Date of first presentation DD.MM.YYYY

Role during firework
O Bystander O Operator O Unknown O others: please specify _________________

Injured eyes
O Right Eye O Left Eye O Both Eyes

Firework type
O Rocket
(Translation: German: Rakete; French: fusée; Italian: razzo pirotecnico)

O Crackers
(Translation: German: Knallkörper/Böller; French: pétard; Italian: petardo)

O Volcano fountain
(Translation: German: Fontäne/Vulkan; French: pétard; Italian: petardo)

O Ground Spinners
(Translation: not available)

O Others: please specify _________________
O Unknown

Alcohol abuse at time point of firework injury
O Yes O No O Unknown O Others: please specify _________________

Drug abuse at time point of firework injury
O Yes O No O Unknown O Others: please specify _________________

Other parts of the body injured

☐ None
☐ Other parts of the head/face beside of eyes and lid
☐ Hands/fingers
☐ Arm
☐ Lower extremities
☐ Trunk
☐ Unknown
☐ Others: please specify ___________________

Ophthalmological diagnosis before injury

☐ **Right Eye**	☐ **Left Eye**
☐ None ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Amblyopia ☐ Glaucoma ☐ Cataract ☐ Status post cataract surgery ☐ Status post refractive surgery Type of intervention_________________ ☐ Status post Lid surgery; Type of intervention_________________ ☐ Status post retinal surgery Type of intervention_________________ ☐ Status post glaucoma surgery Type of intervention_________________ ☐ Status post trauma Please specify ___________________ ☐ Unknown ☐ Others: please specify ___________________ ___________________	☐ None ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Amblyopia ☐ Glaucoma ☐ Cataract ☐ Status post cataract surgery ☐ Status post refractive surgery Type of intervention_________________ ☐ Status post Lid surgery; Type of intervention_________________ ☐ Status post retinal surgery Type of intervention_________________ ☐ Status post glaucoma surgery Type of intervention_________________ ☐ Status post trauma Please specify ___________________ ☐ Unknown ☐ Others: please specify ___________________ ___________________

Best corrected visual acuity after injury

Please provide information about both eyes in case of bilateral injury. In case of unilateral injury cross out the unaffected eye.

☐ Right Eye (if injured)	☐ Left Eye (if injured)
I. At first presentation: O Unknown O Non-light perception O Light perception O Hand movement O Finger counting O Decimal scale: X.XX (0.05 – 1.6) O Others: please specify __________________	**I. At first presentation:** O Unknown O Non-light perception O Light perception O Hand movement O Finger counting O Decimal scale: X.XX (0.05 – 1.6) O Others: please specify __________________
II. One-year follow-up: O No one-year follow-up O Unknown O Non-light perception O Light perception O Hand movement O Finger counting O Decimal scale: X.XX (0.05 – 1.6) O Others: please specify __________________	**II. One-year follow-up:** O No one-year follow-up O Unknown O Non-light perception O Light perception O Hand movement O Finger counting O Decimal scale: X.XX (0.05 – 1.6) O Others: please specify __________________
III. At last follow-up DD.MM.YYYY O No follow-up O Unknown O Non-light perception O Light perception O Hand movement O Finger counting O Decimal scale: X.XX (0.05 – 1.6) O Others: please specify __________________	**III. At last follow-up** DD.MM.YYYY O No follow-up O Unknown O Non-light perception O Light perception O Hand movement O Finger counting O Decimal scale: X.XX (0.05 – 1.6) O Others: please specify __________________

Intraocular pressure (IOP)
Please provide information about both eyes in case of bilateral injury. In case of unilateral injury cross out the unaffected eye.

☐ **Right Eye** (if injured)	☐ **Left Eye** (if injured)
I. At first presentation: O XX mmHg O Unknown **Under IOP lowering therapy** O Yes O No O Unknown O Others: ________________ **St. p. Glaucoma surgery** MM.YYYY O Yes O No O Unknown *- if yes, specify* ______________________	**I. At first presentation:** O XX mmHg O Unknown **Under IOP lowering therapy** O Yes O No O Unknown O Others: ________________ **St. p. Glaucoma surgery** MM.YYYY O Yes O No O Unknown *- if yes, specify* ______________________
II. One-year follow-up: O XX mmHg O No one-year follow-up O Unknown O Others:________________ **Under IOP lowering therapy** O Yes O No O Unknown O Others: ________________ **St. p. Glaucoma surgery** MM.YYYY O Yes O No O Unknown *- if yes, specify* ______________________	**II. One-year follow-up:** O XX mmHg O No one-year follow-up O Unknown O Others:________________ **Under IOP lowering therapy** O Yes O No O Unknown O Others: ________________ **St. p. Glaucoma surgery** MM.YYYY O Yes O No O Unknown *- if yes, specify* ______________________
III. At last follow-up DD.MM.YYYY**:** O XX mmHg O No follow-up O Unknown O Others:________________ **Under IOP lowering therapy** O Yes O No O Unknown O Others: ________________ **St. p. Glaucoma surgery** MM.YYYY O Yes O No O Unknown *- if yes, specify* ______________________	**III. At last follow-up** DD.MM.YYYY**:** O XX mmHg O No follow-up O Unknown O Others:________________ **Under IOP lowering therapy** O Yes O No O Unknown O Others: ________________ **St. p. Glaucoma surgery** MM.YYYY O Yes O No O Unknown *- if yes, specify* ______________________

Maximal Intraocular Pressure (IOP)

Please provide information about both eyes in case of bilateral injury. In case of unilateral injury cross out the unaffected eye.

☐ **Right Eye** (if injured)	☐ **Left Eye** (if injured)
I. In the first week: O Max. XX mmHg on DD.MM.YYYY O No follow-up O Unknown O Others:_________________	**I. In the first week:** O Max. XX mmHg on DD.MM.YYYY O No follow-up O Unknown O Others:_________________
II. In the first month: O Max. XX mmHg on DD.MM.YYYY O No follow-up O Unknown O Others:_________________	**II. In the first month:** O Max. XX mmHg on DD.MM.YYYY O No follow-up O Unknown O Others:_________________
III. In the first year: O Max. XX mmHg on DD.MM.YYYY O No follow-up O Unknown O Others:_________________	**III. In the first year:** O Max. XX mmHg on DD.MM.YYYY O No follow-up O Unknown O Others:_________________

Findings at first presentation

Please provide information about both eyes in case of bilateral injury. In case of unilateral injury cross out the unaffected eye.

☐ **Right Eye** (if injured)	☐ **Left Eye** (if injured)
Anterior segment findings	**Anterior segment findings**
I. Lid and lacrimal system	**I. Lid and lacrimal system**
☐ None	☐ None
☐ Eyelid laceration	☐ Eyelid laceration
☐ Traumatic ptosis	☐ Traumatic ptosis
☐ Lid burn	☐ Lid burn
☐ Charred eyelashes	☐ Charred eyelashes
☐ Canalicular laceration	☐ Canalicular laceration
☐ Others_____________	☐ Others_____________
II. Conjunctiva and sklera	**II. Conjunctiva and sklera**
☐ None	☐ None
☐ Hyposphagma	☐ Hyposphagma
☐ Chemosis	☐ Chemosis
☐ Conjunctival foreign body	☐ Conjunctival foreign body
☐ Ash	☐ Ash
☐ Solid particles	☐ Solid particles
☐ Conjunctival burn	☐ Conjunctival burn
☐ Conjunctival laceration, if yes	☐ Conjunctival laceration, if yes
O XX mm x XX mm	O XX mm x XX mm
O unknown	O unknown
O others: ___________	O others: ___________
☐ superior	☐ superior
☐ inferior	☐ inferior
☐ temporal	☐ temporal
☐ nasal	☐ nasal
☐ Scleral laceration; if yes:	☐ Scleral laceration; if yes:
O > 3.5mm away from the limbus	O > 3.5mm away from the limbus
O < 3.5mm away from the limbus	O < 3.5mm away from the limbus
O Others: ____________	O Others: ____________
☐ Corneoscleral laceration	☐ Corneoscleral laceration
☐ Others_____________	☐ Others_____________
III. Cornea	**III. Cornea**
☐ None	☐ None
☐ Corneal foreign body	☐ Corneal foreign body
☐ central	☐ central
☐ peripheral	☐ peripheral
☐ others: ___________	☐ others: ___________
☐ Corneal burn	☐ Corneal burn

☐ central	☐ central
☐ peripheral	☐ peripheral
☐ others: ___________	☐ others: ___________
☐ Corneal epithelial defect	☐ Corneal epithelial defect
☐ central	☐ central
☐ peripheral	☐ peripheral
☐ others: ___________	☐ others: ___________
☐ Corneal perforation	☐ Corneal perforation
☐ central	☐ central
☐ peripheral	☐ peripheral
O tissue defect: XX mm x XX mm	O tissue defect: XX mm x XX mm
O cut: XX mm	O cut: XX mm
O unknown	O unknown
O others: ___________	O others: ___________
☐ Corneal laceration; if yes:	☐ Corneal laceration; if yes:
☐ central	☐ central
☐ peripheral	☐ peripheral
O area: XX mm x XX mm	O area: XX mm x XX mm
O cut: XX mm	O cut: XX mm
O unknown	O unknown
O others: ___________	O others: ___________
☐ Others___________	☐ Others___________
IV. Anterior chamber, iris, lens, pupil	**IV. Anterior chamber, iris, lens, pupil**
☐ None	☐ None
☐ Iridodialysis	☐ Iridodialysis
☐ Aniridia	☐ Aniridia
☐ Traumatic mydriasis	☐ Traumatic mydriasis
☐ Intracameral foreign body	☐ Intracameral foreign body
☐ Traumatic iritis	☐ Traumatic iritis
☐ 0.5+ ☐ 1+ ☐ 2+ ☐ 3+	☐ 0.5+ ☐ 1+ ☐ 2+ ☐ 3+
☐ Hyphemia, if yes:	☐ Hyphemia, if yes:
O Height in mm XX	O Height in mm XX
O Total Hyphemia	O Total Hyphemia
O Others ___________	O Others ___________
☐ RAPD (relative afferent pupillary defect)	☐ RAPD (relative afferent pupillary defect)
☐ Angle recession	☐ Angle recession
☐ Lens subluxation	☐ Lens subluxation
☐ Lens dislocation	☐ Lens dislocation
☐ Traumatic cataract	☐ Traumatic cataract
☐ Ciliary body detachment	☐ Ciliary body detachment
☐ Others ___________	☐ Others: ___________
Posterior segment findings	**Posterior segment findings**
☐ None	☐ None
☐ Vitreous hemorrhage	☐ Vitreous hemorrhage

☐ Retinal hemorrhage ☐ Retinal contusion/ Berlin's edema ☐ Traumatic optic neuropathy ☐ Retinal detachment ☐ Choroidal detachment ☐ Choroidal rupture ☐ Traumatic retinal foramen ☐ Giant retinal tear ☐ Traumatic macular hole ☐ Intravitreal foreign body ☐ Retinal foreign body ☐ Endophthalmitis ☐ Others _____________	☐ Retinal hemorrhage ☐ Retinal contusion/ Berlin's edema ☐ Traumatic optic neuropathy ☐ Retinal detachment ☐ Choroidal detachment ☐ Choroidal rupture ☐ Traumatic retinal foramen ☐ Giant retinal tear ☐ Traumatic macular hole ☐ Intravitreal foreign body ☐ Retinal foreign body ☐ Endophthalmitis ☐ Others _____________
General findings ☐ None ☐ Globe rupture ☐ Traumatic ophthalmoplegia ☐ Orbital fracture ☐ Traumatic retrobulbar hemorrhage ☐ Others _____________	**General findings** ☐ None ☐ Globe rupture ☐ Traumatic ophthalmoplegia ☐ Orbital fracture ☐ Traumatic retrobulbar hemorrhage ☐ None ☐ Others _____________

Primary surgical management

O Yes O No O Unknown **If yes**, please fill out the table:

Please provide information about both eyes in case of bilateral injury. In case of unilateral injury cross out the unaffected eye.

☐ **Right Eye** (if injured)	☐ **Left Eye** (if injured)
☐ Globe exploration ☐ Canthotomy ☐ Eyelid suture ☐ Conjunctival suture repair ☐ Extraction of conjunctival foreign bodies ☐ Scleral suture repair ☐ Symblepharon ring ☐ Abrasio ☐ Corneal suture repair ☐ Corneoscleral suture repair ☐ Extraction of corneal foreign bodies ☐ Penetrating keratoplasty à chaud ☐ Amniotic membrane graft ☐ Iris repair ☐ Lensectomy without intraocular lens insertion ☐ Lensectomy with intraocular lens insertion ☐ Extraction of intraocular foreign bodies ☐ Anterior chamber washout ☐ Laser coagulation of a retinal foramen ☐ Cryotherapy of a retinal foramen ☐ Vitrectomy O Gas O Silicon Oil O BSS ☐ Cryotherapy ☐ Endolaser ☐ Retinectomy ☐ Enucleation/Evisceration ☐ Others: please specify ________________________ ________________________	☐ Globe exploration ☐ Canthotomy ☐ Eyelid suture ☐ Conjunctival suture repair ☐ Extraction of conjunctival foreign bodies ☐ Scleral suture repair ☐ Symblepharon ring ☐ Abrasio ☐ Corneal suture repair ☐ Corneoscleral suture repair ☐ Extraction of corneal foreign bodies ☐ Penetrating keratoplasty à chaud ☐ Amniotic membrane graft ☐ Iris repair ☐ Lensectomy without intraocular lens insertion ☐ Lensectomy with intraocular lens insertion ☐ Extraction of intraocular foreign bodies ☐ Anterior chamber washout ☐ Laser coagulation of a retinal foramen ☐ Cryotherapy of a retinal foramen ☐ Vitrectomy O Gas O Silicon Oil O BSS ☐ Cryotherapy ☐ Endolaser ☐ Retinectomy ☐ Enucleation/Evisceration ☐ Others: please specify ________________________ ________________________

Primary non-surgical (systemic and topical) management
O Yes O No O Unknown **If yes**, please fill out the table:
Please provide information about both eyes in case of bilateral injury. In case of unilateral injury cross out the unaffected eye.

☐ **Right Eye** (if injured)	☐ **Left Eye** (if injured)
Topical ☐ Irrigation ☐ Artificial tears ☐ Intravitreal antibiotics ☐ Topical antibiotics ☐ Topical corticosteroids ☐ Topical NSAR ☐ Cycloplegics ☐ IOP lowering agents, topical ☐ Bandage lens **Systemic** ☐ Systemic antibiotics (oral and intravenous) ☐ Systemic NSAR ☐ Systemic corticosteroids ☐ IOP lowering agents, oral ☐ Tetanus Prophylaxis ☐ Others: please specify ______________________	**Topical** ☐ Irrigation ☐ Artificial tears ☐ Intravitreal antibiotics ☐ Topical antibiotics ☐ Topical corticosteroids ☐ Topical NSAR ☐ Cycloplegics ☐ IOP lowering agents, topical ☐ Bandage lens **Systemic** ☐ Systemic antibiotics (oral and intravenous) ☐ Systemic NSAR ☐ Systemic corticosteroids ☐ IOP lowering agents, oral ☐ Tetanus Prophylaxis ☐ Others: please specify ______________________

Hospitalization:
Hospitalization directly after the trauma and first presentation
O Yes O No
- **If yes**: hospitalization for XXX days

Secondary hospitalization at later time points (e.g. due to complications or surgeries during follow-up)
O Yes O No
- **If yes**: hospitalization for a total of XXX days

Duration of sick leave:
☐ 100% over XXX day(s) or XXX month(s) or XXX year(s)
☐ 50% over XXX day(s) or XXX month(s) or XXX year(s)
☐ Other: ___ % over XXX day(s) or XXX month(s) or XXX year(s)
☐ Other: ___ % over XXX day(s) or XXX month(s) or XXX year(s)
☐ Invalidity/disability since DD.MM.YYYY; XXX %
(German: Invalidenversicherung; French: l'assurance-invalidité; Italian: sull'assicurazione invalidità)
☐ Unknown
☐ None
☐ Others: please specify __________________

Number of ophthalmological consultations: XXX

Secondary Complications

O Yes O No O Unknown **If yes**, please fill out the table:

Please provide information about both eyes in case of bilateral injury. In case of unilateral injury cross out the unaffected eye.

☐ **Right Eye** (if injured)	☐ **Left Eye** (if injured)
☐ Entropion ☐ Ectropion ☐ Trichiasis ☐ Symblepharon ☐ Corneal scar ☐ central ☐ peripheral ☐ total ☐ unknown ☐ others: ____________ O XX mm x XX mm ☐ Corneal decompensation ☐ Corneal perforation ☐ central ☐ peripheral O tissue defect: XX mm x XX mm O cut: XX mm O unknown O others: ____________ ☐ Keratoconjunctivitis sicca ☐ Limbal Stem Cell Deficiency ☐ Cataract (traumatic, postoperative etc.) ☐ Steroid induced ocular hypertension ☐ Secondary glaucoma O steroid induced glaucoma O unknown etiology O others: ____________ ☐ Uveitis ☐ anterior ☐ intermedia ☐ posterior ☐ Phtisis bulbi ☐ Macular scarring ☐ Retinal detachment, Macula on ☐ Retinal detachment, Macula off ☐ Retinal scar ☐ Retinal Foramina ☐ Macular Foramina ☐ Choroidal neovascularization	☐ Entropion ☐ Ectropion ☐ Trichiasis ☐ Symblepharon ☐ Corneal scar ☐ central ☐ peripheral ☐ total ☐ unknown ☐ others: ____________ O XX mm x XX mm ☐ Corneal decompensation ☐ Corneal perforation ☐ central ☐ peripheral O tissue defect: XX mm x XX mm O cut: XX mm O unknown O others: ____________ ☐ Keratoconjunctivitis sicca ☐ Limbal Stem Cell Deficiency ☐ Cataract (traumatic, postoperative etc.) ☐ Steroid induced ocular hypertension ☐ Secondary glaucoma O steroid induced glaucoma O unknown etiology O others: ____________ ☐ Uveitis ☐ anterior ☐ intermedia ☐ posterior ☐ Phtisis bulbi ☐ Macular scarring ☐ Retinal detachment, Macula on ☐ Retinal detachment, Macula off ☐ Retinal scar ☐ Retinal Foramina ☐ Macular Foramina ☐ Choroidal neovascularization

☐ Traumatic optic neuropathy ☐ Sympathetic ophthalmia ☐ Others: please specify ______________________ ______________________	☐ Traumatic optic neuropathy ☐ Sympathetic ophthalmia ☐ Others: please specify ______________________ ______________________

Secondary non-surgical (systemic and topical) management

O Yes O No O Unknown **If yes**, please fill out the table:
Please provide information about both eyes in case of bilateral injury. In case of unilateral injury cross out the unaffected eye.

☐ **Right Eye** (if injured)	☐ **Left Eye** (if injured)
Topical ☐ Artificial tears ☐ Autologous serum eye drops ☐ Intravitreal antibiotics ☐ Topical antibiotics ☐ Topical corticosteroids ☐ Topical NSAR ☐ Topical Immunosuppressants (e.g. Ikervis) ☐ Cycloplegics ☐ IOP lowering agents, topical ☐ Bandage lens ☐ Anti-VEGF ☐ Intravitreal corticosteroids ☐ Others: please specify ______________________ ______________________ **Systemic** ☐ Systemic NSAR ☐ Systemic antibiotics (oral and intravenous) ☐ Systemic corticosteroids ☐ Systemic Immunosuppressants ☐ IOP lowering agents, oral ☐ Others: please specify ______________________ ______________________	**Topical** ☐ Artificial tears ☐ Autologous serum eye drops ☐ Intravitreal antibiotics ☐ Topical antibiotics ☐ Topical corticosteroids ☐ Topical NSAR ☐ Topical Immunosuppressants (e.g. Ikervis) ☐ Cycloplegics ☐ IOP lowering agents, topical ☐ Bandage lens ☐ Anti-VEGF ☐ Intravitreal corticosteroids ☐ Others: please specify ______________________ ______________________ **Systemic** ☐ Systemic NSAR ☐ Systemic antibiotics (oral and intravenous) ☐ Systemic corticosteroids ☐ Systemic Immunosuppressants ☐ IOP lowering agents, oral ☐ Others: please specify ______________________ ______________________

Secondary surgical management

O Yes O No O Unknown **If yes**, please fill out the table:
In case of consecutive surgeries, please fill in the dates in the sub item.
Please provide information about both eyes in case of bilateral injury. In case of unilateral injury cross out the unaffected eye.

☐ **Right Eye** (if injured)	☐ **Left Eye** (if injured)
☐ **Repair of eyelid**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Electrical depilation**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ Symblepharon ring MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Symblepharon separation**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Conjunctival flap**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Corneal suture repair**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Scleral suture repair**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Corneoscleral suture repair**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Corneal transplantation** ☐ Penetrating keratoplasty ☐ DALK (Deep Anterior Lamellar Keratoplasty) ☐ DMEK (Descemet Membrane Endothelial Keratoplasty) ☐ DSAEK (Descemet's Stripping Endothelial Keratoplasty) 1. MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Limbal stem cell transplant**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Amniotic membrane graft**,MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Phototherapeutic keratectomy**	☐ **Repair of eyelid**, DD. MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Electrical depilation**, DD. MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ Symblepharon ring MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Symblepharon separation**, DD. MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Conjunctival flap**, DD. MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Corneal suture repair**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Scleral suture repair**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Corneoscleral suture repair**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Corneal transplantation** ☐ Penetrating keratoplasty ☐ DALK (Deep Anterior Lamellar Keratoplasty) ☐ DMEK (Descemet Membrane Endothelial Keratoplasty) ☐ DSAEK (Descemet's Stripping Endothelial Keratoplasty) 1. MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Limbal stem cell transplant**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Amniotic membrane graft**, MM. YYYY 2. MM. YYYY 3. MM. YYYY ☐ **Phototherapeutic keratectomy**

1. MM. YYYY	1. MM. YYYY
2. MM. YYYY	2. MM. YYYY
3. MM. YYYY	3. . MM. YYYY
☐ **Keratoprostehsis,** MM. YYYY	☐ **Keratoprostehsis,** MM. YYYY
☐ **Iris repair**, MM. YYYY	☐ **Iris repair**, MM. YYYY
2. MM. YYYY	2. . MM. YYYY
3. MM. YYYY	3. MM. YYYY
☐ **Peripheral iridectomy**, MM. YYYY	☐ **Peripheral iridectomy**, MM. YYYY
2. MM. YYYY	2. MM. YYYY
3. MM. YYYY	3. . MM. YYYY
☐ **Laser peripheral iridotomy,** MM. YYYY	☐ **Laser peripheral iridotomy,** MM. YYYY
2. MM. YYYY	2. MM. YYYY
3. MM. YYYY	3. . MM. YYYY
☐ **Lensectomy with intraocular lens insertion,** MM. YYYY	☐ **Lensectomy with intraocular lens insertion,** MM. YYYY
☐ **Secondary intraocular lens insertion**	☐ **Secondary intraocular lens insertion**
1. MM. YYYY	1. MM. YYYY
2. MM. YYYY	2. MM. YYYY
3. MM. YYYY	3. MM. YYYY
☐ **Laser coagulation of a retinal foramen**	☐ **Laser coagulation of a retinal foramen**
1. MM. YYYY	1. MM. YYYY
2. MM. YYYY	2. MM. YYYY
3. MM. YYYY	3. MM. YYYY
☐ **Cryotherapy of a retinal foramen**	☐ **Cryotherapy of a retinal foramen**
1. MM. YYYY	1. MM. YYYY
2. MM. YYYY	2. MM. YYYY
3. MM. YYYY	3. MM. YYYY
☐ **Vitrectomy**, MM. YYYY	☐ **Vitrectomy**, MM. YYYY
2. MM. YYYY	2. MM. YYYY
3. MM. YYYY	3. MM. YYYY
☐ Gas	☐ Gas
☐ Silicon Oil	☐ Silicon Oil
☐ BSS	☐ BSS
☐ Cryotherapy	☐ Cryotherapy
☐ Endolaser	☐ Endolaser
☐ Retinectomy	☐ Retinectomy
☐ **Glaucoma surgery**	☐ **Glaucoma surgery**
☐ Trabeculectomy, MM. YYYY	☐ Trabeculectomy, MM. YYYY
☐ Deep sclerectomy, MM. YYYY	☐ Deep sclerectomy, MM. YYYY
☐ Stents/Tubes, MM. YYYY	☐ Stents/Tubes, MM. YYYY
☐ Others : ________________________, MM. YYYY	☐ Others : ________________________, MM. YYYY
☐ **Eviszeration/Enucleation** MM. YYYY	☐ **Eviszeration/Enucleation** MM. YYYY
☐ **Others:**	☐ **Others:**
________________________,MM. YYYY	________________________, MM. YYYY
________________________,MM. YYYY	________________________,MM. YYYY

____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY	____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY ____________________, MM. YYYY