





Identification Data

Name	
Aadhar No.	
Race	
Sex	
Age	
Mobile	

History

Date & Time of Injury	Place of Injury	Date & Time of Examination

Eye Protection	Safety Goggles <input type="checkbox"/>	Spectacles <input type="checkbox"/>	Sunglasses <input type="checkbox"/>	Face Shield <input type="checkbox"/>	Others (specify)	No protection <input type="checkbox"/>
Intent of injury	Unintentional <input type="checkbox"/>	Self-inflicted <input type="checkbox"/>	Assault <input type="checkbox"/>	By stander <input type="checkbox"/>		
Work related (Yes/No) <input type="checkbox"/>	Occupation	Object causing injury	Activity			
Alcohol/Drug Abuse	Yes/No <input type="checkbox"/>			Details :		
Eye involved	RE only <input type="checkbox"/>	LE only <input type="checkbox"/>	Bilateral <input type="checkbox"/>			
Whether normal prior to injury	Yes/No <input type="checkbox"/>			If no, details :		

Clinical Examination

Open Globe Injury	OD			OS		
Type Laceration (Penetration/Perforation/IOFB) or Rupture or Mixed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grade - Vision (BCVA)						
Pupil – RAPD/Reverse RAPD/No RAPD						
Zone I. Cornea and limbus II. Limbus to 5 mm posterior into sclera III. Posterior to 5 mm from the limbus	I. <input type="checkbox"/>			I. <input type="checkbox"/>		
	II. <input type="checkbox"/>			II. <input type="checkbox"/>		
	III. <input type="checkbox"/>			III. <input type="checkbox"/>		

Closed Globe Injury	OD			OS		
Type Contusion or Lamellar Laceration or Superficial foreign body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grade - Vision (BCVA)						
Pupil – RAPD/Reverse RAPD/No RAPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Zone I. External (bulbar conjunctiva, sclera, cornea) II. Anterior segment (anterior segment and the pars plicata) III. Posterior segment (internal structures posterior to the posterior lens capsule)	I. <input type="checkbox"/>			I. <input type="checkbox"/>		
	II. <input type="checkbox"/>			II. <input type="checkbox"/>		
	III. <input type="checkbox"/>			III. <input type="checkbox"/>		

Lid

	RE (Yes / No)		LE (Yes / No)	
Laceration	Full / Partial thickness <input type="checkbox"/> <input type="checkbox"/>		Full / Partial thickness <input type="checkbox"/> <input type="checkbox"/>	
Lid margin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involving lacrimal drainage apparatus (which structure?)	Punctum	Canaliculus	Punctum	Canaliculus
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Common duct	Lacrimal sac	Common duct	Lacrimal sac
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Conjunctiva

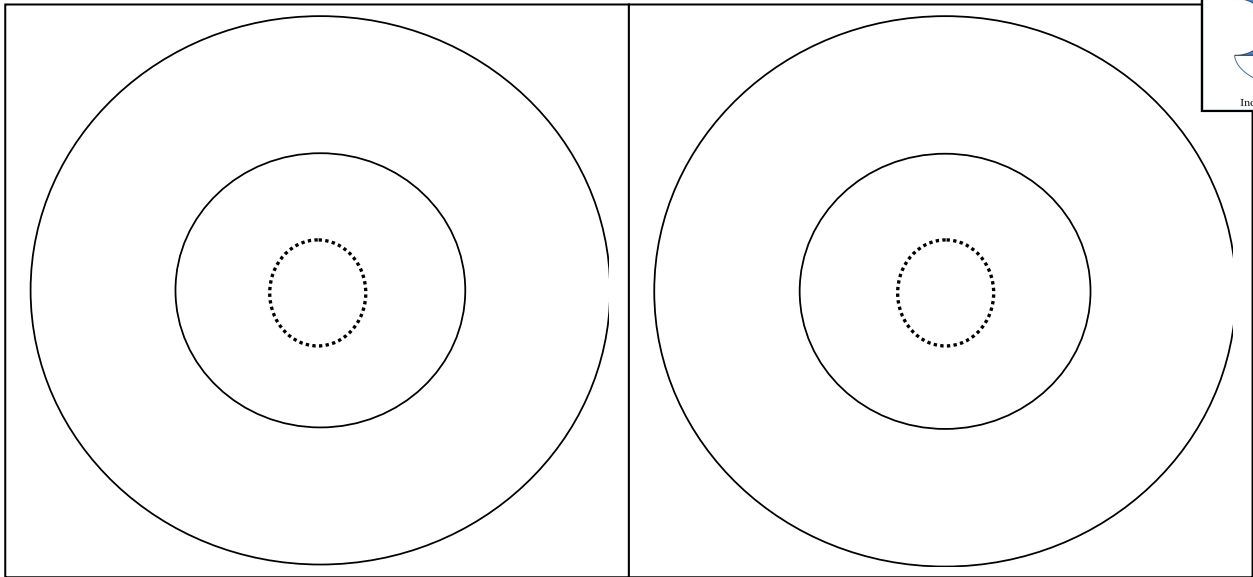
	RE	LE
Chemosis/Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Laceration with length of tear	<input type="checkbox"/>	<input type="checkbox"/>
Subconjunctival Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>

Cornea

	RE	LE
Laceration (Full / Partial Thickness) with length of tear	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Infiltrates	<input type="checkbox"/>	<input type="checkbox"/>
Epithelial Defects	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body	<input type="checkbox"/>	<input type="checkbox"/>

Sclera

	RE	LE
Laceration with length of tear	<input type="checkbox"/>	<input type="checkbox"/>
Infiltrates	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body	<input type="checkbox"/>	<input type="checkbox"/>



	RE	LE
Tissue in wound	Iris <input type="checkbox"/> Vitreous <input type="checkbox"/> Lens <input type="checkbox"/>	Iris <input type="checkbox"/> Vitreous <input type="checkbox"/> Lens <input type="checkbox"/>
	Choroid <input type="checkbox"/> Retina <input type="checkbox"/>	Choroid <input type="checkbox"/> Retina <input type="checkbox"/>
Anterior chamber contents	Hyphaema <input type="checkbox"/>	Hyphaema <input type="checkbox"/>
	Hypopyon <input type="checkbox"/>	Hypopyon <input type="checkbox"/>
	Inflammation <input type="checkbox"/>	Inflammation <input type="checkbox"/>
	Flat chamber <input type="checkbox"/>	Flat chamber <input type="checkbox"/>
IOP:	mm Hg	mm Hg
Lens	Clear <input type="checkbox"/> Disrupted <input type="checkbox"/>	Clear <input type="checkbox"/> Disrupted <input type="checkbox"/>
	Cataract <input type="checkbox"/> Subluxated <input type="checkbox"/>	Cataract <input type="checkbox"/> Subluxated <input type="checkbox"/>
	Dislocated <input type="checkbox"/> Extruded <input type="checkbox"/>	Dislocated <input type="checkbox"/> Extruded <input type="checkbox"/>
If dislocated	Ant. chamber <input type="checkbox"/> Vit. Cavity <input type="checkbox"/>	Ant. chamber <input type="checkbox"/> Vit. Cavity <input type="checkbox"/>
Posterior chamber contents	Vit hmg <input type="checkbox"/> Exudates <input type="checkbox"/>	Vit hmg <input type="checkbox"/> Exudates <input type="checkbox"/>
	Endophthlmitis : <input type="checkbox"/>	Endophthlmitis : <input type="checkbox"/>

Retina

		RE (Macula involvement Y/N)	LE (Macula involvement Y/N)
Hemorrhage		<input type="checkbox"/>	<input type="checkbox"/>
Break	Macular Hole	<input type="checkbox"/>	<input type="checkbox"/>
	Giant Tear	<input type="checkbox"/>	<input type="checkbox"/>
Edema (commotio)		<input type="checkbox"/>	<input type="checkbox"/>
Detachment Rhegmatogenous/Exudative/Tractional/Mixed			

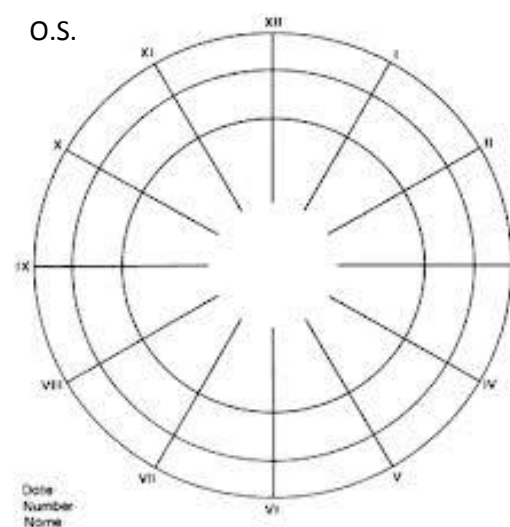
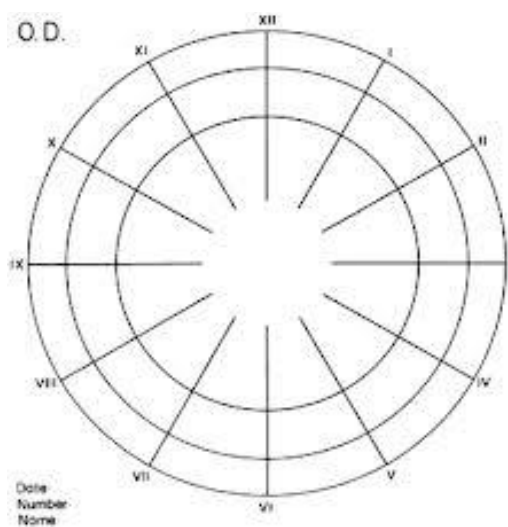
Choroid

	RE (Macula involvement Y/N)	LE (Macula involvement Y/N)
Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>
Rupture	<input type="checkbox"/>	<input type="checkbox"/>
Detachment	<input type="checkbox"/>	<input type="checkbox"/>

Optic nerve:

Injury	RE				LE			
	Avulsion	Edema	Pallor	TRON	Avulsion	Edema	Pallor	TRON
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fundus :



IOFB:

	RE		LE	
Type of IOFB. If non-metallic, specify	Metallic <input type="checkbox"/>	Non-metallic <input type="checkbox"/>	Metallic <input type="checkbox"/>	Non-metallic <input type="checkbox"/>
Location of IOFB	Anterior chamber <input type="checkbox"/> Retina <input type="checkbox"/>	Vitreous <input type="checkbox"/> Others: <input type="checkbox"/>	Anterior chamber <input type="checkbox"/> Retina <input type="checkbox"/>	Vitreous <input type="checkbox"/> Others: <input type="checkbox"/>

	RE	LE
EOM		
Hirschberg		

Orbit :

	OD	OS
Blowout Fractures	No/Floor/Medial Wall/Both <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No/Floor/Medial Wall/both
Muscle incarceration (Y/N)	<input type="checkbox"/> <input type="checkbox"/> No/Yes If Yes,	No/Yes If Yes,
Diplopia	<input type="checkbox"/> Primary Gaze <input type="checkbox"/> Non-Primary <input type="checkbox"/> Monocular <input type="checkbox"/> Binocular	<input type="checkbox"/> Primary Gaze <input type="checkbox"/> Non-Primary <input type="checkbox"/> Monocular <input type="checkbox"/> Binocular

Investigations

Bscan :

OD	OS

UBM :

OD	OS

CT Scan orbit & Brain :

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OTS

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	OD	OS
Variables	Raw points	Raw points
Initial vision		
NPL/enucleation/evisceration	60	60
LP/HM	70	70
1/60 – 5/60	80	80
6/60 – 6/15	90	90
≥ 6/12	100	100
Rupture	-23	-23
Endophthalmitis	-17	-17
Perforating injury	-14	-14
Retinal detachment	-11	-11
RAPD	-10	-10
Total Ocular Trauma Score		

Predictability :

<i>Step 3: Conversion of raw points into the OTS and calculating the likelihood of the final visual categories</i>						
Sum of the Raw Points	OTS	NLP	LP/HM	1/200–19/200	20/200–20/50	≥20/40
0–44	1	74%	15%	7%	3%	1%
45–65	2	27%	26%	18%	15%	15%
66–80	3	2%	11%	15%	31%	41%
81–91	4	1%	2%	3%	22%	73%
92–100	5	0%	1%	1%	5%	94%

Treatment

Eyelid – Full/Partial Repair <input type="checkbox"/> <input type="checkbox"/>		Lacrimal Repair <input type="checkbox"/>		Globe exploration <input type="checkbox"/>	
Cornea Laceration/Rupture repair		<input type="checkbox"/>		<input type="checkbox"/>	
Penetrating Keratoplasty/TKP		<input type="checkbox"/>		<input type="checkbox"/>	
Scleral Laceration/Rupture		<input type="checkbox"/>		<input type="checkbox"/>	
IOFB Removal RE/LE/Both	Magnet/Forceps			Ant Segment/ Post Segment/Orbital	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
AC Wash <input type="checkbox"/>			IC Ab (specific)		<input type="checkbox"/>
Iridoplasty <input type="checkbox"/>		Iridotomy <input type="checkbox"/>		Iridectomy <input type="checkbox"/>	
Lens – Repair RE / LE <input type="checkbox"/> <input type="checkbox"/>	ECCE <input type="checkbox"/>	SICS <input type="checkbox"/>	Phaco <input type="checkbox"/>	Pars plana lensectomy <input type="checkbox"/>	
IOL RE / LE <input type="checkbox"/> <input type="checkbox"/>	Aphakia <input type="checkbox"/>	ACIOL [angle/iris] <input type="checkbox"/>	PCIOL [bag/sulcus] <input type="checkbox"/>	Posterior fixated IOL [SFIOL/Iris claw] <input type="checkbox"/>	
RD Px RE / LE <input type="checkbox"/> <input type="checkbox"/>	Laser <input type="checkbox"/>		Cryotherapy <input type="checkbox"/>		Scleral Buckle <input type="checkbox"/>
RD Mx RE / LE <input type="checkbox"/> <input type="checkbox"/>	Pneumatic Retinopexy <input type="checkbox"/>		Scleral Buckling <input type="checkbox"/>		Vitrectomy <input type="checkbox"/>
Vitrectomy RE / LE <input type="checkbox"/> <input type="checkbox"/>	Anterior / Posterior <input type="checkbox"/>	Open-sky / Pars Plana <input type="checkbox"/>	IVAb (specify) <input type="checkbox"/>	Gas (C3F8/SF6) / Silicone Oil / Heavy S.O.) <input type="checkbox"/>	
Orbital fracture repair : RE / LE <input type="checkbox"/> <input type="checkbox"/>					
Evisceration RE / LE <input type="checkbox"/> <input type="checkbox"/>			Enucleation RE / LE <input type="checkbox"/> <input type="checkbox"/>		