

DIABETIC RETINOPATHY EVALUATION

Patient Information

Name: _____ DOB: _____
Date of Exam: _____ Health Plan ID: _____
Health Plan: _____

Primary Care Physician Information

Physician: _____ Fax: _____
Address: _____ Phone: _____
City: _____ State: _____ ZIP: _____

FINDINGS

- No diabetic retinopathy is found in either eye. **OR**
- RETINAL EXAM ABNORMALITIES DETECTED, AS FOLLOWS:
- Background changes noted in:
- | | | | |
|--------------------------------------------------------|------------------------------------------------|----------|--------|
| <input type="checkbox"/> Right (<i>Circle Grade</i>) | Mild | Moderate | Severe |
| | Clinically significant diabetic macular edema? | Yes | No |
| <input type="checkbox"/> Left (<i>Circle Grade</i>) | Mild | Moderate | Severe |
| | Clinically significant diabetic macular edema? | Yes | No |
- Proliferative changes noted in:
- | | | |
|--------------------------------------------------------|--------|------------------|
| <input type="checkbox"/> Right (<i>Circle Grade</i>) | Active | Regressed/Stable |
| <input type="checkbox"/> Left (<i>Circle Grade</i>) | Active | Regressed/Stable |

FOLLOW UP

- Routine follow-up exam is recommended in one year. **OR**
- Follow-up of abnormalities in my office is recommended in _____ (timeframe).
- Referral to Dr. _____ is recommended in _____ (timeframe).
- Cataracts or Glaucoma detected **OR** laser treatment is needed. Letter to follow.

Thank you for referring this patient for diabetic retinal evaluation.

Sincerely,

_____(Signature)

_____(Practitioner's Printed Last Name)

Please fax or mail this document to the patient's Primary Care Physician identified above.