

DIABETES EYE EXAMINATION REPORT
Outcome Report/Request

Patient Name: _____ **Date of Birth:** ____ / ____ / ____

From: Phone #: _____ - _____ - _____	To: <input type="checkbox"/> Primary Care Physician: _____ Fax #: _____ - _____ - _____ <input type="checkbox"/> Endocrinologist: _____ Fax #: _____ - _____ - _____
---	---

Exam Findings: <input type="checkbox"/> Dilated Fundus Exam Performed Diagnosis: <input type="checkbox"/> No Diabetic Retinopathy <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Management Plan: <input type="checkbox"/> No treatment is necessary at this time, just yearly monitoring for any changes. <input type="checkbox"/> Close monitoring of ocular health status with a review in ____ months. <input type="checkbox"/> Referral to: _____ <input type="checkbox"/> An appointment has been made with: _____	Date Examined: ____ / ____ / ____ <div style="border: 1px solid black; height: 100px; margin-top: 5px;">Additional Ocular Findings:</div> <div style="border: 1px solid black; height: 100px; margin-top: 5px;">Treatment Rendered</div>
--	--

Please Print Physician's Name