DIABETES EYE EXAMINATION REPORT
Outcome Report/Request

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

From:	**To:**
	❑ **Primary Care Physician:** _____
	Fax #: _____ - _____ - _____
	❑ **Endocrinologist:** _____
Phone #: _____ - _____ - _____	Fax #: _____ - _____ - _____

Exam Findings: **Date Examined:** ____ / ____ / _____

❑ **Dilated Fundus Exam Performed**

Diagnosis:

❑ **No Diabetic Retinopathy**

❑ Diabetic Retinopathy
- ❑ Mild
- ❑ Moderate
- ❑ Severe

Additional Ocular Findings:

Management Plan:

❑ No treatment is necessary at this time, just yearly monitoring for any changes.

❑ Close monitoring of ocular health status with a review in ____ months.

❑ Referral to: _____

Treatment Rendered

❑ An appointment has been made with: _____

_____

_____
Please Print Physician's Name

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