FREDERICK
Integrated Healthcare
Network

Diabetes Eye Exam Referral and Fax Back Form

Please perform a dilated retinal examination for this patient as part of an evaluation for diabetic retinopathy, and record the results below. This brief summary will be included in the patient's chart.

____ ____________

Patient First Name **Patient Last Name** **Date of Birth**

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Date of Request

PRIMARY CARE PROVIDER NAME:	**EYE CARE SPECIALIST PROVIDER NAME:**
Address: Fax:	Address: Phone:

Findings: ☐ **No Diabetic Retinopathy**
☐ **Diabetic Retinopathy** (☐ **Progressive)**

☐ Proliferative ☐ R ☐ L
☐ Non-proliferative ☐ R ☐ L (Severity:_______________)
☐ Macular Edema ☐ R ☐ L

☐ Cataracts ☐ R ☐ L
☐ Glaucoma ☐ R ☐ L
☐ Macular Degeneration ☐ Pre-Macular Degeneration ☐ R ☐ L

ICD-10 Code (Optional): ____________ ____________ ____________ ____________

Additional Comments:

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Recommended Follow-Up: ☐ **12 mths** ☐ **6 mths** ☐ **4 mths** ☐ **3 mths**

☐ Other ____

__________________ ____

Date of Exam **Signature of Eye Care Specialist**

(Please fax to the number above for the patient's Primary Care Provider)