

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

Date of Request

PRIMARY CARE PROVIDER NAME:

EYE CARE SPECIALIST PROVIDER NAME:

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:

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)