DIABETES EYE EXAM
CONSULTATION REQUEST AND REPORT

Date of Request: _____

Dear Dr. _____

Thank you for participating in the mutual care of this patient. As this patient's primary care provider, I am requesting a dilated retinal examination for the evaluation of diabetic retinopathy. The brief summary below will be included in this patient's medical chart. Thank you for your efforts.

☒ **PLEASE FAX OR MAIL TO PRIMARY CARE PROVIDER**

Patient Name: _____
Last First MI

DOB: _____ Medical Record #: _____

Primary Care Provider: _____

Address: _____

Phone: _____ Fax: _____

Dilated Retinal Exam Findings

Date of Exam _____

Findings: ☐No diabetic retinopathy or macular edema R / L / Both
☐Mild or moderate diabetic retinopathy or macular edema R / L / Both
☐Sight-threatening (severe) diabetic retinopathy or macular edema R / L / Both

Additional Comments: _____

Recommended Follow-up: ☐12 months ☐6 months ☐Other _____

☐Education/education materials given

Eye Care Provider_____ (MD/OD)

Address_____

_____

Phone _____Fax _____

