

Diabetes Eye Exam Report

TO: _____	Clinic/Office _____
	Address: _____
Phone: _____	Fax: _____

Patient Name: _____ DOB: _____

Visual Acuity: _____ R _____ L Intraocular Pressure _____ L _____ R

Retinal Examination Findings:

- _____ No retinopathy or past retinopathy and should be examined in one year
- _____ Needs no laser now, but should return in _____ months because of risk of developing diabetic macular edema (DME) or high risk of proliferative diabetic retinopathy (PDR)
- _____ Diabetic macular edema requiring focal laser photocoagulation
- _____ High risk proliferative diabetic retinopathy or iris neovascularization requiring panretinal photocoagulation
- _____ Tractional retinal detachment or vitreous hemorrhage requiring vitrectomy

Other Ocular Conditions

_____ Not Applicable

Cataracts:

- _____ Does interfere with activities of daily living
- _____ Does not interfere with activities of daily living

Glaucoma:

- _____ Controlled
- _____ Sub-optimally controlled

Plan of Treatment:

Follow-up _____ weeks/months

_____ Refer to Retina Specialist OR:

(check appropriate treatment plan)

(Circle right eye "R" or left eye "L" or both)

- | | | |
|---|---|---|
| _____ Fluorescein angiogram | R | L |
| _____ Panretinal laser photocoagulation | R | L |
| _____ Focal laser photocoagulation | R | L |
| _____ Vitrectomy | R | L |
| _____ Cataract Surgery | R | L |

_____ Other:

Eye Care Provider (M.D. or O.D.)

Print Name: _____ Signature: _____ Date _____

Clinic/Office Name

Phone

Fax

I give permission to release this information to my Physician _____

Patient Signature