For Better Practice: Diabetes Eye Examination Report

To: _____ **Clinic/Office:** _____

(Primary Care Provider)

Address: _____ **Phone:** _____ **Fax:** _____

Patient Name :_____ **Patient ID #:** _____

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

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 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
____ Suboptimally controlled

Plan of Treatment:

____ Refer to retina specialist *or:*

Follow-up in_____weeks/months

(Check appropriate treatment plan) *(Circle right eye "R" left eye "L" or both)*

____ Fluorescein angiography	R	L
____ Panretinal laser photocoagulation	R	L
____ Focal laser photocoagulation	R	L
____ Vitrectomy	R	L
____ Cataract surgery	R	L

____ Other_____

Print Name: _____ _____ _____

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

_____ _____ _____

Clinic/Office Name Phone FAX

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