Diabetic Eye Examination Report

Referring Physician or Office Staff
Please complete the Referring Physician and Patient Information sections. Fax the form to the patient's eye care physician.

Eye Care Physician
Please complete and sign the Eye Care Physician section. Fax or mail the completed form to the physician providing diabetes care.

Referring Physician Information	Patient Information	
Name	Name	
Address	Address	
Fax	Phone Number	Date of Birth

Eye Care Physician		
Eye Care Physician (Please Print)		**Date of Exam**

Dilated Retinal Examination	R	L
No Diabetic Retinopathy Present	☐ R	☐ L
E11.319 Type 2 Diabetes Mellitus with Unspecified Diabetic Retinopathy without Macular Edema		
Mild	☐ R	☐ L
Moderate	☐ R	☐ L
Severe	☐ R	☐ L
E11.359 Type 2 Diabetes Mellitus with Proliferative Diabetic Retinopathy without Macular Edema	☐ R	☐ L
H35.81 Retinal Edema	☐ R	☐ L
Other Ocular Findings:		
Glaucoma	☐ R	☐ L
Cataracts	☐ R	☐ L
AMD	☐ R	☐ L
Other: ______________	☐ R	☐ L

Visual Acuity	IOP
________ R ________ L	________ R ________ L

Recommendations and Plan
- ☐ Monitor Only
- ☐ Additional Testing/Recommendations/Comments:

Follow-up
- ☐ Appointment ______________
- ☐ One Year
- ☐ PRN
- ☐ Other ______________

Physician's Signature	Date