Retinal Eye Exam Communication Report

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Retinal eye examination for diabetic members is recommended annually. Please use this form to ensure the examination results are part of the primary care health record.

Patient:

Schedule an eye exam with an Opthamalogist or Optometrist and take this form with you to your appointment.

Eye Care Specialist:

Please send/fax completed form to the patient's Primary Care Provider.

Primary Care Provider	Ophthalmologist/Optometrist
Name:_____	Name:_____
Address:_____	Address:_____
Phone:_____	Phone:_____
Fax:_____	Fax:_____

Patient Information

Patient Name:_____ **DOB:**_____

Phone:_____

Retinal Eye Exam Findings:

Date Dilated Fundus Eye Exam Completed:_____

No diabetic retinopathy	☐ OS ☐ OD
Diabetic Retinopathy requiring no treatment	☐ OS ☐ OD
Diabetic Retinopathy requiring treatment	☐ OS ☐ OD
Other Eye Disease_____	☐ OS ☐ OD

Additional Findings/Comments:

Recommended follow up:

Ophthalmologist/Optometrist Signature:_____
Date:_____