



## Diabetes Eye Exam Referral and Fax Back Form

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 (PCP)** (complete for patient)

**PCP** \_\_\_\_\_

**Fax** \_\_\_\_\_

**Phone** \_\_\_\_\_

**PCP Address** \_\_\_\_\_

**Patient Name: Last** \_\_\_\_\_ **First** \_\_\_\_\_ **MI** \_\_\_\_\_

**DOB** \_\_\_\_\_ **Year diagnosed with DM** \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

**Dilated Retinal Exam Findings**

Date of dilated eye exam: \_\_\_\_\_

Findings:  No diabetic retinopathy R/L/Both  Diabetic retinopathy R/L/Both

Additional Comments: -

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Recommended Follow-up:  12 months  6 months  Other

Education/education materials given

**Eye Care Specialist (MD/OD) Print:** \_\_\_\_\_

**Address** \_\_\_\_\_

**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_