Diabetic Eye Exam Referral and Communication Form:

Patient's Name: _____ DOB: ___/___/_____ Today's Date: ___/___/_____

You are currently due for your Diabetic Retinal Eye Exam.

Please complete the following:

- » Schedule your appointment as soon as possible with an eye specialist.
- » Inform the scheduler that you need a Diabetic Retinal Eye Exam.
- » Complete the top section of this form and turn it in on the day of your appointment.

Referring Physician/Provider: _____

Address: _____

Phone: _____

Referring Doctor's Fax: _____

Eye Care Specialist: Please fax or mail this form to the primary care provider listed above upon completion of the patient visit. Please include result and recommended follow-up.

Screening Date: _____/_____/_____

Retinal Examination Findings:

- ☐ No Diabetic Retinopathy
- ☐ Retinal Abnormalities detected: _____

Recommended Follow-Up: ☐ 1 year ☐ 2 years ☐ Other _____

Additional comments/treatment plan: _____

_____

Eye Care Specialist's Signature: _____

Printed Name: _____

Please send a copy of the patient's chart/report results to the fax number above.