

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
 Sub-optimally controlled

Plan of Treatment: _____ **Follow-up** _____ weeks/months

Refer to Retina Specialist OR:

(Check appropriate treatment plan)

- Fluorescein angiogram
 Panretinal laser photocoagulation
 Focal laser photocoagulation
 Vitrectomy
 Cataract Surgery
 Other _____

(Circle right eye "R" left eye "L" or both)

R L
R L
R L
R L
R L

Print Name: _____ Signature: _____ Date _____
Eye Care Provider (M.D. or O.D.)

Clinic/Office Name Phone Fax

Print-ready copies of the "Diabetes Eye Examination Report" form can be obtained off the following web site:

New Mexico Ophthalmological Society www.nmos.org

Designed in collaboration with the New Mexico Medical Review Association www.nmmra.org

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