

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:

<i>(Check appropriate treatment plan)</i>	<i>(Circle right eye "R" left eye "L" or both)</i>
<input type="checkbox"/> Fluorescein angiogram	R L
<input type="checkbox"/> Panretinal laser photocoagulation	R L
<input type="checkbox"/> Focal laser photocoagulation	R L
<input type="checkbox"/> Vitrectomy	R L
<input type="checkbox"/> Cataract Surgery	R L
<input type="checkbox"/> Other _____	

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

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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