Diabetes eye exam report

To (eye care provider): _____

Address: _____

Phone/Fax #: _____

Date of eye exam: _____

Please return completed form to the clinic noted on the right.

Return to:

Novant Health: Durham Internal Medicine (clinic name)

_____ (Physician name)

4205 Ben Franklin Blvd, Durham, NC 27704 (address)

919-620-0974 (phone/fax #)

Patient information:

Name: _____ DOB: _____

Last HgbA1c: _____ _____

(date) (results)

Exam findings:

Visual acuity (best corrected) OD: _____ OS: _____

Intraocular pressure OD: ☐ within normal limits ☐ outside normal limits OS: ☐ within normal limits ☐ outside normal limits

☐ Dilated fundus exam performed

Diagnosis:

No diabetic retinopathy	☐ OD	☐ OS
Non-proliferative diabetic retinopathy		
Mild	☐ OD	☐ OS
Moderate	☐ OD	☐ OS
Severe	☐ OD	☐ OS
Proliferative diabetic retinopathy	☐ OD	☐ OS
Clinically significant macular edema	☐ OD	☐ OS

Plan:

☐ Monitor only

-or-

☐ Additional testing/treatment recommended:

Additional ocular findings:

Additional comments:

Management:

☐ Follow-up: _____ months ☐ Referral To: _____ For: _____

☐ Home central vision test (Amsler) given

☐ Patient education/discussion

☐ Information pamphlet given

☐ Other: _____

Doctor Signature: _____ Date: _____ Time: _____

* This form is an adaption of a form developed by the Ohio Optometric Association as part of the National Eye Institute's Healthy Vision 2010 Community Awards Program and a grant from the American Optometric Association's Healthy Recipe Program.

NOVANT HEALTH

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803361 R 07/07/2015

Patient Name:_____

DOB:_____

(or use patient label)

Name / MR # / Label

See back for instructions