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)	*(Circle right eye "R" left eye "L" or both)*	
____ Fluorescein angiogram	R	L
____ Panretinal laser photocoagulation	R	L
____ Focal laser photocoagulation	R	L
____ Vitrectomy	R	L
____ Cataract Surgery	R	L

____ 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

Version 1 NMMRA10/11/00