Diabetic Retinal Eye Exam Consult Form

Patient Information

First Name	Last Name	Date of Birth

Primary Phone Number	Date of Last HbA1C	Most Recent HbA1C

Primary Care Provider (PCP) / Referring Provider Information

PCP Name	Phone Number	Fax Number

Street Address	City, State	Zip

Eye Clinic Results:

Date the dilated retina exam was done: ____________________

Findings (Please choose only one):

______ NO diabetic retinopathy in either eye

______ Diabetic retinopathy in the RIGHT eye

______ Diabetic retinopathy in the LEFT eye

______ Diabetic retinopathy in BOTH eyes

Comments:

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Follow up:

______ Routine follow up in my office in one year. Appointment date: ____________________

______ Follow up in my office in ____________ (specify duration of time). Appointment date: ____________

______ Referral to specialist ____________________ (specify clinic name). Appointment date: ________

Please fax this form back to the PCP or referring provider identified above to ensure continuity of care.
Our mutual goal is the highest quality of care for the patient.

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