EYES ON MAIN

DIABETES EYE EXAMINATION REPORT

EYES ON MAIN APPRECIATES YOUR REFERRAL AND WOULD LIKE TO OFFER 10% OFF MATERIALS FOR YOUR PATIENT!
(INCLUDES COMPLETE SET OF PRESCRIPTION GLASSES/SUNGLASSES, PLANO SUNGLASSES, OR 1 YEAR SUPPLY OF CONTACTS)

To be filled out by the Referring Provider:

From: _____

(Write in or apply company stamp)

To: _____

Date examined: _____

Patient Information:
Name: _____ **Phone Number:** _____ **DOB:** _____

Diabetes mellitus: ☐ Type 1 ☐Type 2 ☐Gestational ☐Prediabetes **HbAIC:** _____ ☐< 6 months ☐≥ 6 months ☐Unknown

Duration of Diabetes (in years)**:** _____ **Current Diabetes Therapy:** ☐Insulin ☐Oral Hypoglycemic ☐Diet Control ☐Other Injectable Therapies ☐None

Results of Last Finger-stick blood glucose reading (per patient)**:** _____ ☐N/A Patient reports under control ☐Yes ☐No

Current Medications (ocular and systemic)**:**

To be filled out by Dr. Loren Rodgers:

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 ed./discussion

☐Info. Pamphlet given

☐Other _____ Doctor's Signature _____