EDWARD/ELMHURST HEALTHCARE

_____

_____

PH: _____ FAX: _____

Eye Exam Results for Diabetic Patients

Date _____

Dear Dr. _____,

I would like to refer you Mr. / Ms. _____ for _____

_____.

As soon as the patient is seen please complete the form below and fax to the primary care provider without a cover sheet.

Best corrected vision compared to last visit.

☐ Unchanged ☐ Better ☐ Worse ☐ No previous visit to compare

Retinal changes compared to last visit:

☐ No retinopathy ☐ Unchanged ☐ Worse ☐ Retinopathy needs Tx Laser / Surgery

For patients with cataracts compared to last visit:

☐ Unchanged ☐ Worse ☐ No previous visit to compare ☐ Cataracts need surgery

Other findings and diagnosis _____

Treatment recommended _____

Return visit _____

Thank you for your professional help in treating our patient.

Eye Care Provider (Print):_____Signature_____

Please provide Dr. _____copies of my medical records as requested

Patient's signature_____ Date_____