

Diabetes Internal Medicine & Endocrinology
8205 E 56th Street Suite 100 Indianapolis, IN 46216
317-621-4044 Fax: 317-621-4050

Dear

Our patient has informed us they had an eye exam done in your office. We would like to have the following information regarding the exam. Please fill out this form and fax it back to our office at your earliest convenience.

Sincerely:
Diabetes Internal Medicine & Endocrinology
FAX: 317-621-4050

Patient Name:
Patient Date of Birth:

Primary Care/Referring Physician:

Date Last Eye Exam: _____

Eye Exam Results: _____

Dilated Fundus Examination

_____ No apparent Diabetic Retinopathy

_____ Background Diabetic Retinopathy

_____ Proliferative Retinopathy

_____ Proliferative Diabetic Retinopathy

_____ Macular Edema

Other Pathology Found: _____

PLAN:

_____ Re-evaluation for Retinopathy in _____ months.

_____ Re-evaluation for progression of Retinopathy in _____ months

_____ Fluorescein angiography w/possible laser treatment to follow

_____ Laser treatment

_____ Other _____

Signature of Ophthalmologist or Optometrist

Printed Name of Ophthalmologist or Optometrist

Date: _____