DIABETIC EYE EVALUATION REPORT

Date ______________________

Patient Name ______________________________ DOB ______________

Primary Care Provider _______________________ Fax # ______________

Endocrinologist ____________________________ Fax # ______________

Consultant Optometrist ____

Duration of Known Diabetes _____________________________________

Most recent A1c _____ % ☐ A1c unknown by patient

Visual acuity: right eye 20/ _______ left eye 20/ _______

Slit lamp exam: Normal ______ Other ____________________________

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Dilated fundus exam:
No diabetic retinopathy _____ right eye _____ left eye

Other findings: ____

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Recheck: Annually ____________ Other __________________________

Comments: ____

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Thank you very much for entrusting your patients to us for their eye care.