Eye examination report for diabetes

Important health screening

Present this form to your eye care professional and ask them to return it to your primary care provider.

FOR PRIMARY CARE PROVIDER TO COMPLETE

Provider name			
Address			
City	State	ZIP	
Phone	Fax		

FOR PATIENT TO COMPLETE

Patient name	Date of birth	
Home address		
City	State	ZIP
Phone	Health insurance plan	

FOR EYE CARE PROFESSIONAL TO COMPLETE

Complete this portion of the form and return it to the primary care provider. Please check a box for Sections A, B, and C.

Eye care professional name	☐ Licensed optometrist ☐ Licensed ophthalmologist
Eye care practice/facility name	☐ Other _____
Address	City / State / ZIP
Phone	Fax

Patient received a dilated fundus examination with the following results:

A. Normal results ☐

B. Macular edema ☐ Absent ☐ Present

C. Diabetic retinopathy

- ☐ None detected
- ☐ Background diabetic retinopathy present
  - ☐ Mild ☐ Moderate ☐ Severe
- ☐ Proliferative diabetic retinopathy present

Recommendations – attach additional sheet if necessary.

- ☐ Monitoring, with follow-up at
  - ☐ 1 year ☐ 2 years
  - ☐ Other interval (indicate timeframe) _____
- ☐ Monitoring only; no additional evaluation or new treatment at this time.
- ☐ Further testing and/or treatment recommended. See comments.

Comments

Date of exam	Patient is to return for re-evaluation in _____ months
Eye care professional's signature	Form was sent to primary care provider: ☐ Fax ☐ Mail Date _____ Initials _____

059030 (02-15-2022)

This form was developed on behalf of your provider by Premera Blue Shield of Alaska.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

An Independent Licensee of the Blue Cross Blue Shield Association