Diabetes Eye Exam Consultation

Sanford Health Plan is concerned with ensuring the continuity and coordination of care of our members with diabetes. In order to improve the lines of communication between our eye care professionals and our member's primary diabetes care provider, we recommend that your clinic utilize this form in providing your patient's primary diabetes care provider with information related to their diabetic eye exams.

Diabetes Care Provider Information

Clinic Name:	Provider Name:	
Patient Name	Patient DOB:	
Street Address:		
City:	State:	Zip:
Phone Number:	Fax Number:	

Eye Exam Clinical Findings and Recommendations

Date Seen: _____

Dilated Eye Exam: Yes ◯ No ◯

Findings:

- ☐ No diabetic retinopathy
- ☐ Early diabetic retinopathy
- ☐ Pre-proliferative disease
- ☐ Proliferative retinopathy
- ☐ Laser therapy in my office is scheduled for _____
- ☐ Referral for therapy made to _____

Other Findings:

- ☐ Macular edema
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Other eye disease _____

Follow-up Planned:

- ☐ Will schedule for annual dilated eye exam
- ☐ Will reschedule re-check in 6 months
- ☐ Will reschedule re-check in 3-6 months
- ☐ Other _____

Eye Care Provider _____

I authorize release of this information to my primary diabetes care provider.

_____

(Patient Signature)