Diabetes Eye Exam Consultation

SANFORD HEALTH PLAN

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)