_____ Action or referral required
_____ For your information

Eye Examination Report

Exam Date _____

To _____ Clinic _____

Phone _____ Fax _____

Patient Name _____ **DOB** _____

Visual Acuity _____**R** _____**L** **Intraocular Pressure** _____**R** _____**L**

Dilated Retinal Examination Findings

_____ No diabetic retinopathy or no changes in retinopathy and should be examined again in one year
_____ Needs no treatment now, but should return in _____ months because of risk of developing diabetic macular edema (DME) or high risk proliferative diabetic retinopathy
_____ Diabetic macular edema requiring focal laser photocoagulation
_____ High risk proliferative diabetic retinopathy or iris neovascularization requiring panretinal photocoagulation
_____ Macular degeneration

Cataracts

_____ Interfering with activities of daily living
_____ Not interfering with activities of daily living

Glaucoma

_____ Controlled
_____ Sub-optimally controlled
_____ Suspect

Other Ocular Conditions _____

Plan of Treatment

Follow-up in _____ **weeks/months**

Refer to _____

Fluorescein angiogram	R	L
Panretinal laser photocoagulation	R	L
Focal laser photocoagulation	R	L
Cataract surgery	R	L

Other _____

Eye Care Provider_____OD/MD/DO Fax _____

Clinic_____ Phone _____

Signature_____ Date _____

Copies of this form can be obtained from Oregon Academy of Ophthalmology at **www.oreyemds.org** or Oregon Optometric Physicians Association at **www.oregonoptometry.org** or OMPRO at **www.ompro.org** 6-08-03
Adapted from a form developed by New Mexico Medical Review Association.

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