



# Idaho Diabetes Eye Examination Referral Form and Report

**Primary Practitioner**

**Eye Practitioner**

**Supporting Organizations**

Blue Cross of Idaho

Cassia Regional Medical Center

Diabetes & Internal Medicine Associates

Humphreys Diabetes Center

Idaho Academy of Family Physicians

Idaho Diabetes Prevention and Control Program

Idaho Medicaid

Idaho Primary Care Association

North Idaho Health Network

Primary Health Medical Group

St. Luke's Internal Medicine

Qualis Health

Regence Blue Shield of Idaho

Saint Alphonsus Medical Group

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Type of Diabetes/Duration (years)	Diabetes Therapy	A1C	Blood Glucose (per patient)
Type 1 <input type="checkbox"/> / <input type="text"/>	Insulin <input type="text"/>	# : <input type="text"/>	<input type="text"/>
Type 2 <input type="checkbox"/> / <input type="text"/>	Oral Hypoglycemic <input type="text"/>	Last test: <input type="text"/>	N/A <input type="checkbox"/>
Gestational <input type="checkbox"/> / <input type="text"/>	Diet Control <input type="text"/>	Unknown	Under Control?
Prediabetes <input type="checkbox"/> / <input type="text"/>	None <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**Date Referred to Eye Practitioner**

Patient: Please take this completed form to your physician

**EYE EXAM FINDINGS**      **Date of Exam:** \_\_\_\_\_

Ocular Findings and Comments

Dilated Fundus Exam Performed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
No Diabetic Retinopathy	<input type="checkbox"/> OD	<input type="checkbox"/> OS
Non-Proliferative Diabetic Retinopathy		
Mild	<input type="checkbox"/> OD	<input type="checkbox"/> OS
Moderate	<input type="checkbox"/> OD	<input type="checkbox"/> OS
Severe	<input type="checkbox"/> OD	<input type="checkbox"/> OS
Improved from previous	<input type="checkbox"/> OD	<input type="checkbox"/> OS
Worse than previous	<input type="checkbox"/> OD	<input type="checkbox"/> OS
Proliferative Diabetic Retin.	<input type="checkbox"/> OD	<input type="checkbox"/> OS
Clinically Signif. Macular Edema	<input type="checkbox"/> OD	<input type="checkbox"/> OS

**MANAGEMENT PLAN**

Follow-up: _____ Months	<input type="text"/>
Referral to:	<input type="text"/>
For:	<input type="text"/>
Home central vision test (Amsler) given	<input type="checkbox"/>
Patient ed./discussion	<input type="checkbox"/>
Info. pamphlet given	<input type="checkbox"/>
Other	<input type="text"/>

Eye Practitioner's Signature: \_\_\_\_\_