MEDICAL GROUP

Diabetic Retinal Eye Exam Report Request

Instructions:

Patient: Please take this form to your eye care professional and have them complete and return. *Diabetic Eye exams are covered under medical insurance and may be subject to your specialist co-pay and/or deductible.*

Eye Care Professional: Please complete and fax back to the primary care provider indicated below.

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This section to be completed by McLaren Clinical Support Staff:

Patient Name: _____ **DOB**: _____
Last First

Primary Care Provider Information:

Provider Name: _____

Phone: _____ Fax: _____

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This section to be filled out by the Eye Care Professional:

Date of Exam: _____ ☐ Follow up recommended?

Results of Dilated Retinal Eye Exam:

☐ No Diabetic Retinopathy

☐ Positive for Retinopathy (Please indicate any further testing or treatment under notes)

Notes: _____

_____

Printed Name of Eye Care Professional: _____

Signature of Eye Care Professional: _____

Office Phone: _____ Office Fax: _____