

Eye care professional report for Dilated Retinal Eye (DRE) exam

Use this completed form to communicate results to your patient's primary care provider.

Patient name	ID #	
DOB	Health plan	
PCP	Phone	FAX
Chief complaint(s)		

		Right eye	Left eye
Tonometry	Date of exam _____	_____ mmHg	_____ mmHg
Retina	Diabetic retinopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Mild non-proliferative diabetic retinopathy (NPDR)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Moderate NPDR	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Severe NPDR	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Proliferate diabetic retinopathy (PDR) - Not high risk	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PDR - high risk	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Pan-retinal photocoagulation (PRP) scars	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Focal scars	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Impression

Eye care professional (signature)

M.D./D.O./O.D.

Eye care professional (printed name)	Date
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Office phone number	Office fax number
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