PrimeWest HEALTH™

Diabetic Eye Exam Form

Patient Information

Name: _____

Date of Birth:_____ Date of Eye Exam:_____

Name of Primary Care Provider: _____

Name of Eye Clinic: _____

Results of Diabetic Eye Exam

Visual acuity (best corrected) OD: _____ OS: _____

Were patient's eyes dilated for this exam? ☐ Yes ☐ No

☐ No diabetic retinopathy

☐ Diabetic retinopathy requiring no treatment

☐ Diabetic retinopathy requiring treatment

☐ Another eye disease

Details:

Recommended follow-up: ☐ 3 months ☐ 6 months ☐ 12 months

Additional Comments

Provider Signature _____ **Date**_____