DIABETES EYE EXAMINATION REPORT FORM

Diabetes Oculo-visual Assessment

To: (Family Doctor) _____ **Doctors Fax/ Email:** _____ **Date:** _____

Patient Name: _____ **Date of Birth:** _____

The above noted patient presented to our clinic for their annual oculo-visual assessment. A thorough dilated fundus examination was completed and a summary of our findings is outlined below:

Type of Diabetes:

- ☐ Type 1 (previously known as IDDM)
- ☐ Type 2 (previously known as NIDDM)

Duration _____ years

Aided Visual Acuity: **OD:** _____ **OS:** _____

Cataracts: **OD:** _____ **OS:** _____

IOP: **OD:** _____ mmHg **OS:** _____ mmHg

Current Diabetes Therapy:

- ☐ Insulin
- ☐ Oral Hypoglycemic
- ☐ Diet Controlled

FUNDOSCOPY

☐ **OD: No diabetic retinopathy** ☐ **OS: No diabetic retinopathy**

☐ **Non-Proliferative Diabetic Retinopathy (NPDR)**

OD	OS
◉ Mild	○ Mild
○ Moderate	○ Moderate
○ Severe	◉ Severe

☐ **Proliferative Diabetic Retinopathy (PDR)**

◉ **OD** ○ **OS**

☐ **Diabetic Macular Edema (DME)**

○ **OD** ○ **OS**

Comments:

_____

_____

_____

_____

_____

_____

Due to the observations presented above, I have elected to:

☐ **Re-evaluate the patient in _____ months**

☐ **Refer the patient to _____ for an assessment and possible treatment**

I will contact you should any new information arise.

Examining Optometrist

OD Name & Practice: _____

Address: _____

City / Province: _____ **Postal Code:** _____

Email: _____ **Phone:** _____

In partnership with:

CANADIAN ASSOCIATION OF OPTOMETRISTS
ASSOCIATION CANADIENNE DES OPTOMÉTRISTES

DIABETES CANADA