

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 |
|--------------------------------|--------------------------------|
| <input type="radio"/> Mild | <input type="radio"/> Mild |
| <input type="radio"/> Moderate | <input type="radio"/> Moderate |
| <input type="radio"/> Severe | <input type="radio"/> 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