From OD Practice:

DIABETES EYE EXAMINATION REPORT FORM

Diabetes Oculo-visual Assessment

To: Family Doctor: _____ Doctor's Fax/Email: _____ Date: _____

Re: (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:

Aided Visual Acuity: OD: _____ OS: _____

Cataracts: OD: _____ OS: _____

IOP: OD: _____ mmHg OS: _____ mmHg

FUNDOSCOPY

☐ OD: No diabe0tic retinopathy ☐ OS: No diabetic retinopathy

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

OD	OS
◯ Mild	◯ Mild
◯ Moderate	◯ Moderate
◯ Severe	◯ Severe

☐ **Proliferative Diabetic Retinopathy (PDR):**

◯ OD ◯ OS

☐ **Clinically Significant Macular Edema (CSME):**

◯ OD ◯ OS

Type of Diabetes:

☐ Type 1 (previously known as IDDM)

☐ Type 2 (previously known as NIDDM)

Duration _____ yrs.

Current Diabetes Therapy:

☐ Insulin

☐ Oral Hypoglycemic

☐ Diet Controllled

Comments:

_____

_____

_____

_____

Due to the observations presented above I have elected to:

☐ Re-evaluate the patient in _____ months time

☐ 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 _____

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DIABETES CANADA