



Member Name: _____

Member ID#: _____

DILATED FUNDUS EXAMINATION
(for the diabetic patient)

Patient:	DOB:	HP ID#:
Primary Physician:	Gender:	Exam Date:
Date of Diabetes Diagnosis:	Date of Last Ophthalmology/Optometry Exam:	
Visual Acuity: Right eye _____ Left eye _____	Uses Insulin: <input type="checkbox"/> Yes <input type="checkbox"/> No	
LABS: Recent glucose _____ Date _____ HbA _{1c} _____ Date _____		

EXAMINATION RESULTS	RIGHT EYE		LEFT EYE	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
1) No diabetic retinopathy				
2) Background diabetic retinopathy				
3) Proliferative diabetic retinopathy				
4) Is clinically significant macular edema present?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5) Are high risk characteristics present?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6) Are there other worrisome findings present? If so, please specify in the space provided below.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7) Is laser treatment indicated? If so, please specify type:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Focal <input type="checkbox"/>	PRP <input type="checkbox"/>	Focal <input type="checkbox"/>	PRP <input type="checkbox"/>
8) Is other treatment indicated? If so, please specify in the space provided below.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Recommended follow-up date: _____

Other findings: _____

Other recommendations or comments: None Specify: _____

Ophthalmologist/Optometrist Signature: _____ Date: _____

Ophthalmologist/Optometrist Name (Please print): _____

Report sent to Primary Care Physician (initial): _____ Date: _____

Report sent to The Health Plan (initial): _____ Date: _____