

# Diabetes Eye Exam Report

The Nebraska Diabetes Guidelines Task Force recommended including a suggested Diabetes Eye Exam Report in the annual guidelines mailing. Several formats were considered and all have merits but the enclosed form was selected as an example for health care professionals to consider for their patients with diabetes. As with all of our flow sheets and health care forms, this may be altered to fit your individual program and copied as needed. Additional copies can be requested from the Diabetes Prevention and Control Program, PO Box 95026, Lincoln, NE 68509, phone: 1-800-745-9311 or e-mail to [diabetes@dhhs.ne.gov](mailto:diabetes@dhhs.ne.gov).

It is suggested that the primary care physician give this form to patient to take with them when they receive their annual dilated eye exam. The examining ophthalmologist or optometrist would complete the form and send or fax it to the patient's primary care physician.

This is part of the Task Force's effort to ensure that people with diabetes receive complete, consistent care for their diabetes that meets the minimum ADA guidelines. Your consideration of using this form, as well as the other enclosed suggested forms, will aid in our efforts to improve the standards of care in Nebraska for all people with diabetes.

Important background rationale to consider:

- Diabetic retinopathy is the most frequent cause of new cases of blindness among adults aged 20-74 years\*
- During the first two decades following the onset of diabetes, nearly all patients with type 1 diabetes and >60% of patients with type 2 diabetes have retinopathy\*
- More than 32,000 people in Nebraska age 18 and older have diabetic retinopathy\*
- Knowledge of the presence of retinopathy is a useful tool for the primary care physician in the overall management of diabetes

The American Diabetes Association recommends a dilated retinal eye examination as an annual standard of care for persons with diabetes:\*

- Under age 10: based on clinical judgement
- Type 1: within 3-5 years of diagnosis
- Type 2: at time of diagnosis of diabetes; annually thereafter. In known pregnancy, dilated eye exam every trimester.

*\*Diabetes Care, Volume 32, Supplement 1, January 2009*

# Diabetes Eye Exam Report

TO: _____	Clinic/Office: _____
Phone: _____	Fax: _____
	Address: _____

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Visual Acuity: \_\_\_\_\_ R \_\_\_\_\_ L      Intraocular Pressure \_\_\_\_\_ R \_\_\_\_\_ L

### Retinal Examination Findings:

- No retinopathy or past retinopathy and should be examined in one year
- Needs no laser now, but should return in \_\_\_\_\_ months because of risk of developing diabetic macular edema (DME) or high risk of proliferative diabetic retinopathy (PDR)
- Diabetic macular edema requiring focal laser photocoagulation
- High risk proliferative diabetic retinopathy or iris neovascularization requiring panretinal photocoagulation
- Tractional retinal detachment or vitreous hemorrhage requiring vitrectomy

### Other Ocular Conditions

Not Applicable

### Cataracts:

- Does interfere with activities of daily living
- Does not interfere with activities of daily living
- Not applicable

### Glaucoma:

- Controlled
- Sub-optimally controlled
- Not applicable

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### Plan of Treatment:

Follow-up \_\_\_\_\_ weeks/months

Refer to Retina Specialist      OR:

*(check appropriate treatment plan)*

*(Circle right eye "R" or left eye "L" or both)*

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Fluorescein angiogram             | R | L | B |
| <input type="checkbox"/> Panretinal laser photocoagulation | R | L | B |
| <input type="checkbox"/> Focal laser photocoagulation      | R | L | B |
| <input type="checkbox"/> Vitrectomy                        | R | L | B |
| <input type="checkbox"/> Cataract Surgery                  | R | L | B |
| <input type="checkbox"/> Other:                            |   |   |   |

Eye Care Provider (M.D. or O.D.)

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Clinic/Office Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

I give permission to release this information to my Physician \_\_\_\_\_

\_\_\_\_\_  
Patient Signature