

Diabetes Dilated Retinal Exam Consultation Request

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Patient Name: _____ DOB: _____

CCHMC Medical Record #: _____

Requesting Physician/Nurse Practitioner: _____

As a component of good diabetes care, the Cincinnati Children's Hospital Medical Center, Diabetes Center is requesting a consultation for a dilated retinal eye exam on our patient who has had Type ____ Diabetes since _____. So that we may maintain accurate records on this patient, please **FAX back this sheet to (513) 636-5450.**

Date of Exam: _____

Retinal Examination Findings:

- No retinopathy or past retinopathy.
- Non-proliferative diabetic retinopathy: _____
- Proliferative diabetic retinopathy: _____
- Diabetic macular edema: _____
- Other comments: _____

Other Ocular Conditions:

- Not Applicable
- Cataracts: _____
- Glaucoma: _____
- Other: _____

Treatments:

- None required
- Fluorescein angiogram
- Panretinal laser photocoagulation
- Focal laser photocoagulation
- Other: _____
- _____

Follow-Up Recommendation: _____

Eye Care Provider:

Signature: _____

Name: _____

Address: _____

Phone/Fax: _____

