Cincinnati Children's Hospital Medical Center

Diabetes Dilated Retinal Exam Consultation Request

DIABETES CENTER

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(513) 636-2444
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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) 636-7576**.

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/Credentials:_____

Name: _____

Address: _____

_____

Phone/Fax: _____

DTK1066