

Diabetic Eye Examination and Glaucoma Screening Report

Outcome Report/Request for Co-Managing Health Care Professional

Please fax primary care provider (PCP) and UPMC Health Plan:

PCP: _____

Fax: _____ Phone: _____

UPMC Health Plan Fax: 412-454-6240

Patient Information

Name: _____ DOB: _____

Insurance Type: _____ Member ID: _____

Diabetes Information:

Diabetes mellitus: Type 1 DM Type 2 DM Pre-Diabetes Gestational

Duration of Diabetes (years): ____ Current Diabetes Therapy: Insulin Oral hypoglycemic Diet control None

Results of last finger-stick blood glucose reading (per patient): _____ N/A HbA1c: _____ Unknown

Under control? (Per patient) Yes No

Current Medications (ocular and systemic):

Exam Findings:

Date of Exam: _____

Visual Acuity (best corrected) OD: _____ OS: _____

Dilated fundus exam performed

Diagnosis:

No diabetic retinopathy OD OS

Non-proliferative diabetic retinopathy

Mild OD OS

Moderate OD OS

Severe OD OS

Proliferative diabetic retinopathy OD OS

Clinically significant macular edema OD OS

Additional Ocular Findings:

Additional Comments:

Intraocular Pressure OD: ____ mmHG OS: ____ mmhg @AM/PM

Plan: Monitor Only OR Additional Treatment Recommended:

Management:

Follow-up: ____ Months Referral to: _____ For: _____

Amsler grid given

Patient education/discussion

Informational pamphlet given

Other: _____

Eye care specialist: _____ (MD/OD/DO)

Doctor's signature: _____

Phone: _____

Fax: _____