Diabetes Eye Exam Referral and Fax Back Form

You play an important part in managing your health. Please share this with your eye care professional.

Thank you for participating in the care of this patient. As this patient's primary care provider, I am requesting a dilated retinal examination for the evaluation of diabetic retinopathy. The brief summary below will be included in this patient's chart.

lease complete your contact information or stamp your information in the space provided below. Inst Name Last Name State ZIP Phone Family Medicine for McHenry County 1095 Pingree Rd., Suite 108 Crystal Lake, IL 60014 (815) 459-6655 EYE CARE SPECIALIST Please provide your dilated retinal exam findings and complete your contact information below fax this form to the primary care provider listed above. Date of Exam Findings: No Diabetic Retinopathy Diabetic Retinopathy Recommended Follow-up: 12 months G MD OD TO TO TO TO TO TO TO TO TO	itient First Name	Patient Last Name DOB
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The information provided on this form will not be shared with Novo Nordisk. All releases of patient health information should be made in accordance with privacy policies.

