# 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.

Date of Request

Patient First Name | Patient Last Name | DOB

## PRIMARY CARE PROVIDER

**Please complete your contact information or stamp your information in the space provided below.**

First Name | Last Name

City | State | ZIP

Fax: 847.658.9922 | 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 ○ R ○ L ○ Both

Additional Comments

Recommended Follow-up: ☐ 12 months ☐ 6 months

Eye Care Specialist Name: ☐ MD ☐ OD

City | State | ZIP

Fax | Phone

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.

The Diabetes Education Program

 Printed in the U.S.A. 0513-00015556-1 August 2013

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