FOCUS ON DIABETES™ Look closer at Eye Health | American Diabetes Association® Connected for Life

# Diabetes Eye Exam Referral

**From:** ☐ PCP ☐ Endocrine ☐ Other: _____

**To:** _____ **Fax:** _____

**Patient:** _____ **DOB:** _____ **MRN:** _____

**Date of Referral:** _____ **Last Reported Eye Exam:** months/years ago _____

**Pertinent Diabetes History:**

☐ Prediabetes ☐ Type 1 diabetes ☐ Type 2 diabetes ☐ Other (please specify): _____

Last reported A1C: _____ % Goal A1C: _____ % CGM use: ☐ Yes ☐ No

Current time in range (e.g. glucose 70–180 mg/dL): _____ % Goal time in range: _____ %

Diabetes-related medications: _____

Comorbidities: ☐ Hypertension ☐ Nephropathy ☐ Prior retinopathy ☐ Neuropathy
☐ Cardiovascular disease ☐ Sleep apnea ☐ Other (please specify): _____

Please perform a dilated retinal exam and send findings to our office.

The next appointment with our office is: _____

Sincerely,

Clinician Name: _____ Practice Name: _____