Eye Exam Referral for Diabetic Patients

<Insert the name of referring physician's clinic along with phone and email address here>

Doctor's Address :	
Doctor's Phone :	

Date _______________

Dear Dr. ___________________________ ,

I would like to refer you Mr. / Ms. __________________________ for ____________________________

____.

As soon as the patient is seen please fax back this form without cover sheet to <Your Fax Number> with the following information:

Best corrected vision compared to last visit.

☐ Unchanged ☐ Better ☐ Worse ☐ No previous visit to compare

Retinal changes compared to last visit:

☐ No retinopathy ☐ Unchanged ☐ Worse ☐ Retinopathy needs Tx Laser / Surgery

For patients with cataracts compared to last visit:

☐ Unchanged ☐ Worse ☐ No previous visit to compare ☐ Cataracts need surgery

Other findings and diagnosis ____

Treatment recommended ____

Return visit _______________________

Thank you for your professional help in treating our patient.

<Your Name> MD. ___________________

Please provide Dr. <Your Name> copies of my medical records as requested

Patient's signature_______________________ Date________________