Eye care professional report for Dilated Retinal Eye (DRE) exam

Use this completed form to communicate results to your patient's primary care provider.

Patient name	ID #	
DOB	Health plan	
PCP	Phone	FAX
Chief complaint(s)		

		Right eye	Left eye
Tonometry	**Date of exam** ________________	________ mmHg	________ mmHg
Retina	Diabetic retinopathy	☐ Yes ☐ No	☐ Yes ☐ No
	Mild non-proliferative diabetic retinopathy (NPDR)	☐ Yes ☐ No	☐ Yes ☐ No
	Moderate NPDR	☐ Yes ☐ No	☐ Yes ☐ No
	Severe NPDR	☐ Yes ☐ No	☐ Yes ☐ No
	Proliferate diabetic retinopathy (PDR) - Not high risk	☐ Yes ☐ No	☐ Yes ☐ No
	PDR - high risk	☐ Yes ☐ No	☐ Yes ☐ No
	Pan-retinal photocoagulation (PRP) scars	☐ Yes ☐ No	☐ Yes ☐ No
	Focal scars	☐ Yes ☐ No	☐ Yes ☐ No

Impression	
Eye care professional (signature) M.D./D.O./O.D.	
Eye care professional (printed name)	Date
Office phone number	Office fax number