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**