## Ophthalmology Care Visit Continuity and Coordination Report



Today's date	
Patient name:	Date of birth:
Dilated Retinal Exam Date:	_
Dx:	
To:(Primary Care/Referring Physician)	
Address:	Phone:
	Fax:
Your patient, who has diabetes, was examined in this office on results are as follows:	the above date. Their dilated retinal examination
<ul> <li>□ No diabetic retinopathy</li> <li>□ Positive for background retinopathy</li> <li>□ Positive for proliferative diabetic retinopathy</li> </ul>	
Comments:	
This information is being sent to you for your review and inclusive your patient was reminded that an annual dilated retinal examinophthalmologist or optometrist.  Recommendations: Dilated retinal follow-up visit in one year, 6 months, 3 months or	ation should be performed annually by an
Specific retinal therapy or laser treatment? Y / N If yes, date	::
Respectfully submitted,	
(Examining Provider Signature)	
Printed Name:	Phone:
Address:	-
	-
	-

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