DIABETES
EYE EXAM REPORT

Health Partners
A division of Senior Care Systems, P.A.

Fax to **Health Partners: 910-686-4715** or

Mail to **Health Partners**: 1013 Porters Neck Rd., Suite 100; Wilmington, NC 28411

Fill in the following information and take to your eye care professional. Your eye care provider will complete the information about your eye exam. You may mail this report to our office at the address above or bring it to your next appointment OR have your eye care professional fax this to our office at the number provided above. This is an important part of your medical record and needs to be reviewed by your primary care physician.

Name: _____ Date of Birth: _____

Primary Care Physician: ☐ Dr. Audrey Sutton-Surak ☐ Dr. Marsha Fretwell

TO BE COMPLETED BY EYE CARE PROVIDER

OD	OS	Finding(s)
		No evidence of Diabetic Retinopathy
		Mild to Moderate Nonproliferative Diabetic Retinopathy
		Early (Non-high risk) Proliferative Diabetic Retinopathy
		Severe Nonproliferative Diabetic Retinopathy

Date of exam: _____ Were the eyes dilated? ☐ Yes ☐ No

_____ _____

Eye Care Practitioner's Name (Please Print) Eye Care Practitioner's Signature

Comments:

Any questions, please call our office at 910-686-1099