

Date: [Date]

To: Dr. [PCP Name]

Fax/Address: [PCP Address or Fax Number]

RE: Diabetic Eye Examination Report

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Date of Exam: [Date of Exam]

Dear Dr. [PCP Last Name],

I performed a comprehensive dilated diabetic eye examination on the patient listed above. Below are the findings and clinical plan:

Visual Acuity:

Right Eye (OD): 20/ []

Left Eye (OS): 20/ []

Ocular Findings:

- **Right Eye (OD):** [] No Diabetic Retinopathy | [] Non-Proliferative (Mild/Mod/Severe) | [] Proliferative
- **Left Eye (OS):** [] No Diabetic Retinopathy | [] Non-Proliferative (Mild/Mod/Severe) | [] Proliferative
- **Macular Edema:** [] Present | [] Absent
- **Other Findings:** [Glaucoma, Cataracts, etc.]

Assessment/Plan:

[Describe treatment initiated, referrals made, or stability of condition.]

Follow-Up:

The patient is scheduled to return to my office in [Number] months for a follow-up evaluation.

Thank you for the opportunity to participate in this patient's care. Please contact my office if you have any questions.

Sincerely,

[Provider Signature]

[Provider Name, OD/MD]

[Clinic Name]

[Phone Number]