



**Ophthalmology/Optometry**  
**Continuity and Coordination Report**

\_\_\_\_\_  
 Today's Date

**Re:**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Dilated Retinal Eye Exam Date:** \_\_\_\_\_

**To:**

\_\_\_\_\_  
 (Primary Care/Referring Physician)

**Address:**

\_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Fax \_\_\_\_\_

Your patient, who has diabetes, was examined in this office on the above date. Their dilated retinal examination results are as follows:

\_\_\_\_\_ No diabetic retinopathy

\_\_\_\_\_ Background diabetic retinopathy

\_\_\_\_\_ Proliferative diabetic retinopathy

Comments: \_\_\_\_\_

This information is being sent for your review and inclusion in their medical record.

During the examination, your patient was reminded that an annual dilated retinal examination should be performed annually by an ophthalmologist or optometrist.

Recommendations:

\_\_\_ Dilated retinal follow-up visit in one year or \_\_\_\_\_

\_\_\_ Specific retinal therapy/laser treatment

Respectfully submitted,

\_\_\_\_\_  
 (Examining Provider Signature)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

CC: \_\_\_\_\_