To Eye Care Professional:

In an effort to improve communication regarding our diabetic patient’s annual dilated retinal eye exam, we kindly ask that you complete and return this form OR your consultation form to Watson Clinic LLP via FAX to 1-866-426-2690.

We thank you in advance for your assistance in maintaining the health of our shared patients.

The above patient has been seen in my office for a retinal exam on __________________ (DATE) with the following findings:

- Diabetic retinopathy
- Intermediate _____ Neg _____ Pos _____
- Background diabetic retinopathy
  - OD _____ OS _____ OU _____
- Proliferative diabetic retinopathy
  - OD _____ OS _____ OU _____
- Dilated Funduscopic Exam performed
  - Yes _____ No _____

Other Findings: ____________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Recommendations:
- Follow up visit in ______________________________________________________
- Other: __________________________________________________________________

Please Print Physician Name ________________________________________________

Signature of Ophthalmologist/Optometrist _______________________________ Date ________________