Diabetic retinopathy - screening saves sight

Information for your doctors

Please ask your family doctor or diabetes doctor to fill out this card, and take it with you when you next visit your eye specialist

Patient information

Name: _____

Date of birth: _____

Gender: M ☐ F ☐

Type of diabetes: Type 1 ☐ Type 2 ☐

or other: _____

Referral source contact details

Name (printed): _____

Profession: _____

Organization: _____

Address: _____

Tel: _____

Date of diabetes diagnosis: _____

Reason for referral: _____

Latest HbA_{1c} reading: _____ Latest blood pressure reading: _____

Current tobacco use: Yes ☐ No ☐

Current medications: _____

_____

_____

International Diabetes Federation

The Fred Hollows Foundation

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Diabetic retinopathy - screening saves sight

Information for your doctors

Please give this to your eye specialist to complete after your examination, and take it with you to the next appointment with your family doctor or diabetes doctor

Retinal examination results

Date of examination: _____

Type of examination(s): _____

_____

_____

_____

Ophthalmologist's contact details

Name (printed): _____

Profession: _____

Organization: _____

Address: _____

Tel: _____

Results of examination

☐ **Non-proliferative diabetic retinopathy detected**
Comments: _____

☐ **Proliferative diabetic retinopathy detected**
Comments: _____

☐ **Diabetic maculopathy detected**
Comments: _____

Further comments: _____

_____

_____

_____

_____

_____

Date of next retinal examination:

_____

_____

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