KAISER PERMANENTE

Eye Exam Form

Patient Instructions:

1. Schedule an eye exam with an Optometrist or Ophthalmologist.
2. Fill in **Section 1** with your name, date of birth, and Medical Record Number.
3. Take this form to an eye doctor and have them complete **Section 2 and 3**.
4. Provide a copy of this form to your primary care doctor or ask the eye doctor to send/fax it to your primary care doctor (fax number provided below).
5. Keep a copy of this form for your files.

Please fax completed report to: 1-866-480-8086

Section 1 (To be completed by patient)

Name: _____ DOB: _____ MRN: _____
Kaiser Permanente Physician: _____

Section 2 (To be completed by Ophthalmologist/Optometrist)

Eye Exam Date: _____

Exam Results:

	R Right Eye	**L** Left Eye
No Diabetic Retinopathy	☐	☐
Background Diabetic Retinopathy	☐	☐
Proliferative Diabetic Retinopathy	☐	☐
Macular Degeneration	☐	☐
Glaucoma	☐	☐
Glaucoma - Suspect	☐	☐
No Evidence of Glaucoma	☐	☐

Other Pathology: _____

Follow-up Eye Exam recommendation:

_____3 Months _____6 Months _____1 Year _____Other

_____This note has been included in patient's medical record.

_____

Signature of Ophthalmologist/Optometrist

Section 3 (To be completed by Ophthalmologist/Optometrist)

Ophthalmologist/Optometrist Printed Name: _____
Address: _____
Phone: _____ Fax: _____

Mail completed form to: 4000 DeKalb Technology Parkway ♦ Suite 200 ♦ Atlanta, GA 30340