

Eye Care Providers – Complete and Fax to (770) 219-2848

Patient Name: _____

Date of Birth: _____

Date of Exam: _____

Type of Exam: _____

Retinal Exam

Right Eye

- ☐ **No** Diabetic Retinopathy present
- ☐ **Yes** Diabetic Retinopathy:
- ☐ Unspecified
 - ☐ Mild
 - ☐ Moderate
 - ☐ Severe
 - ☐ Proliferative

- ☐ Macular (retinal) Edema
- ☐ Glaucoma
- ☐ Cataracts
- ☐ AMD
- ☐ Other: _____

Plan & Recommendations

- ☐ Monitor Only
- ☐ Refer to Specialist
- ☐ Additional Testing / Recommendations / Comments

Left Eye

- ☐ **No** Diabetic Retinopathy present
- ☐ **Yes** Diabetic Retinopathy:
- ☐ Unspecified
 - ☐ Mild
 - ☐ Moderate
 - ☐ Severe
 - ☐ Proliferative

- ☐ Macular (retinal) Edema
- ☐ Glaucoma
- ☐ Cataracts
- ☐ AMD
- ☐ Other: _____

Next Eye Exam Follow-up

- ☐ One Year
- ☐ PRN
- ☐ Appt _____

Exam Provider:

☐ *Ophthalmologist*

☐ *Optometrist*

Date: _____

Ophthalmologist / Optometrist Signature: _____

Ophthalmologist / Optometrist Printed Name: _____

Additional Contact: _____

Questions or inquires: NGPG Quality Dept – ngpg.clinical.quality@nghs.com or 770-848-7156

Longstreet Population Health Dept – 678-207-4444



DM EYE EXAM FORM



505010-06121

NGMC FORM # 505010-06121 (1/28/26)