PRIMARY CARE PROVIDER COMMUNICATION FORM

Date_____ PCP Name_____ PCP Fax _____

The following patient received an eye exam in my office on _____. In an effort to ensure coordination of care, I am including my exam findings and follow-up recommendations. Please contact me if you would like additional information.

PATIENT INFORMATION

Patient Name _____

Date of Birth _____ Phone _____

FINDINGS

□ Retinal exam demonstrated abnormalities

Eye Conditions Include:

□ Diabetic Retinopathy □ Cataracts □ Macular degeneration

□ Glaucoma □ Ocular surface disease □ Other_____

Potential Health Conditions Include:

□ High Cholesterol □ Hypertension □ Other_____

RECOMMENDED FOLLOW-UP

□ Follow-up exam is scheduled in my office on _____

□ Follow-up of abnormalities in my office is recommended in _____

□ Recommended consultation with Dr. _____

□ Phone _____ within _____

Comments _____

_____

_____

_____

REFERRING OPTOMETRIST

Practice Name_____

Address _____

City _____ State_____ ZIP Code _____

Phone_____ Fax _____

Optometrist Name _____ Optometrist Signature_____

see well. be well.