KETTERING Health Network

Practice Name

Practice Name

Address

Address

Phone Fax

DIABETES PATIENT EYE EXAMINATION REPORT

Date of exam: _____

Patient name: _____ DOB: _____

Seen by (please print name): _____

Patient received a dilated fundus examination with the following results:

- ❒ **No diabetes retinopathy was detected.**
- ❒ **Diabetes retinopathy was detected, but only requires monitoring.**
- ❒ **Retinopathy requiring further testing and/or treatment was detected.**
  - ❒ **Macular edema** ❒ **Right eye** ❒ **Left eye**
  - ❒ **Proliferative retinopathy** ❒ **Right eye** ❒ **Left eye**

Plan of treatment:

Patient to return for re-evaluation in _____ weeks/months.

Signature: _____ Date: _____

Please fax completed form to: _____
Fax Number

Diabetic Eye Exam	
CPT/CPT II	67028, 67030-31, 67036, 67039-43, 67101, 67105, 67107-08, 67110, 67112-13, 67121, 67141, 67145, 67208, 67210, 67218, 67220-21, 67227-28, 92002, 92004, 92012, 92014, 92018-19, 92134, 92225-28, 92230, 92235, 92240, 92250, 92260, 99203-05, 99213-15, 99242-45, 2022F, 2024F, 2026F, 3072F
HCPCS	S0620, S0621, S3000