Continuity and Coordination of Care

Eye Care Consultation for Diabetic Patients

MVP Member: Complete **Section 1** of this form, then give the form to your eye doctor.

MVP Member's Eye Doctor: Please complete **Section 2** and fax the completed form to the Member's Primary Care Physician (PCP) indicated in Section 1.

Section 1: To Be Completed by the MVP Member *(please print)*

MVP Member Name	Member Date of Birth

MVP Member PCP's Name	PCP's Fax No. ( )

PCP's Street Address	City	State	Zip Code

Section 2: To Be Completed by MVP Member's Eye Doctor

Date of Exam

The above-named patient was examined by me on the date indicated, and a dilated fundus examination was performed.

- ☐ No diabetic retinopathy was detected.
- ☐ Background retinopathy was detected and requires monitoring. No treatment indicated.
- ☐ Retinopathy requiring further testing and/or treatment was detected.

Comments

The patient was instructed to return for re-evaluation in _____ months. Please contact me if additional information is needed.

PCP Name and Title	Phone No. ( )