

# 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

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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. (       )
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