

# Report of Dilated Fundus Exam

TO	
EXAMINATION DATE	day / month / year
PATIENT'S NAME	First name / Last name
DATE OF BIRTH	day / month / year

Patient Reported History of	<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Other:
Visual Acuity Aided / Unaided	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU
Intraocular Pressure	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> mmHg@ <input type="checkbox"/> NCT/Appl.

Results of Dilated Fundus Examination	
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RIGHT EYE	LEFT EYE
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Optic Nerve	<input type="checkbox"/> No Abnormalities <input type="checkbox"/> Neovascularization <input type="checkbox"/> Edema	<input type="checkbox"/> No Abnormalities <input type="checkbox"/> Neovascularization <input type="checkbox"/> Edema
Hemorrhages	<input type="checkbox"/> None <input type="checkbox"/> Dot-and-Blot <input type="checkbox"/> Flame	<input type="checkbox"/> None <input type="checkbox"/> Dot-and-Blot <input type="checkbox"/> Flame
Exudates	<input type="checkbox"/> None <input type="checkbox"/> Cotton Wool Spots <input type="checkbox"/> Hard Exudates	<input type="checkbox"/> None <input type="checkbox"/> Cotton Wool Spots <input type="checkbox"/> Hard Exudates
Vascular	<input type="checkbox"/> No Abnormalities <input type="checkbox"/> Microaneurysms <input type="checkbox"/> Venous Beading <input type="checkbox"/> Arteriovenous Crossing Changes <input type="checkbox"/> Retinal Arteriosclerosis <input type="checkbox"/> Intraretinal Microvascular Abnormalities	<input type="checkbox"/> No Abnormalities <input type="checkbox"/> Microaneurysms <input type="checkbox"/> Venous Beading <input type="checkbox"/> Arteriovenous Crossing Changes <input type="checkbox"/> Retinal Arteriosclerosis <input type="checkbox"/> Intraretinal Microvascular Abnormalities
Vitreous	<input type="checkbox"/> No Abnormalities <input type="checkbox"/> Preretinal Hemorrhages <input type="checkbox"/> Vitreous Bands/Fibrovascular Tissue	<input type="checkbox"/> No Abnormalities <input type="checkbox"/> Preretinal Hemorrhages <input type="checkbox"/> Vitreous Bands/Fibrovascular Tissue
Macula	<input type="checkbox"/> No Abnormalities <input type="checkbox"/> Clinically Significant Edema <input type="checkbox"/> Exudates within 500 microns of fovea	<input type="checkbox"/> No Abnormalities <input type="checkbox"/> Clinically Significant Edema <input type="checkbox"/> Exudates within 500 microns of fovea

OTHER FINDINGS	
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Assessment	<input type="checkbox"/> No Retinopathy Noted <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Other	<input type="checkbox"/> Hypertensive Retinopathy <input type="checkbox"/> Non-Proliferative <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
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DUE TO THE OBSERVATIONS PRESENTED ABOVE I HAVE ELECTED TO	Re-evaluate the patient in:	Refer the patient to:
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Signed	PRAC ID
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