# FAX Coversheet for Vision Examination

**Please fill out to improve patient's Health Care**

**To:** Facey Medical Group **Fax#** 818-729-5842

**Eye provider name:** **Eye provider phone#:**

**Eye provider signature:**

**Date of Eye Examination:** ____/____/ 21

☐ **Optometrist**

☐ **Ophthalmologist**

**Patient Name:**

**DOB:** **Gender:**

**Patient PCP:**

| ☐ No Diabetic Retinopathy | ☐ Diabetic Retinopathy Detected |
|---|---|

Comments/Notes:

## Fax Disclosure Information

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Facey Medical Group

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