INLAND EMPIRE HEALTH PLAN

PCP VISION REPORT

TO BE COMPLETED BY THE VISION PROVIDER

Exam Date: _____

Member's Name: _____ DOB: _____

Member's IEHP ID#: _____

☐ CHECK HERE IF MEMBER WAS REFERRED BY THE PCP

FROM:

Vision Provider: _____ Phone: _____

Address: _____ City: _____ Zip: _____

TO: **Forwarded by:** **MAIL** ☐ **FAX** ☐

PCP: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

EXAMINATION FINDINGS

CHECK ALL THAT APPLY:

☐ This was a retinal or dilated Eye Exam for Patients with Diabetes (EED) using a binocular indirect ophthalmoscope to rule out diabetic eye disease. Examination results are as follows:

☐ **Normal Findings** ☐ **Other** ***(please complete section below)***

☐ This was a medical eye visit for evaluation, treatment and management of an acute ocular condition:

(please complete section below)

Symptoms (detail): _____

_____

Diagnosis: _____ **ICD Code:** _____

Procedures / Treatment Plan: _____

_____

Recommendations: _____

Vision Provider: _____ **Date:** _____ **Next Visit:** _____

(signature)

Copy To PCP

Copy Vision Provider File