



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 dilated **Diabetic Retinal Examination (DRE)** 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)

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