



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)

NOTICE:
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