



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)

**NOTICE:**

This facsimile contains confidential information that is being transmitted to and is intended only for the use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution, or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify us by telephone at (909) 890-2054.

Copy  
To PCP

Copy  
Vision Provider File