EYE EXAMINATION REPORT

Date of this report: _____ Patient Telephone #: _____

Applicant's Name: _____ Other Contact Telephone #: _____

Birthdate: _____ Address: _____
(Street)

_____
(City) (State) (Zip Code) (County)

VISUAL ACUITY (With Correction)

	Far	Near
Right eye	_____	_____
Left eye	_____	_____

RX/REFRACTION: Note* CABVI does not provide refraction services. Please indicate when last refraction was conducted. _____

Right eye _____

Left eye _____

VISUAL FIELDS:

Description of Visual Fields _____

***PLEASE ATTACH VISUAL FIELDS AS THEY ARE NEEDED FOR LOW VISION TESTING & REHABILITATION SERVICES**

***PLEASE PROVIDE BOTH CODE AND DESCRIPTION**

Diagnosis Description	**Dx Medicare Code(s) (ICD 10)**
Right eye _____	_____
_____	_____
_____	_____
Left eye _____	_____
_____	_____
_____	_____
_____	_____

PROGNOSIS _____

Names of other doctors providing eye care to this patient (including referrals) _____

Signature of Examining Eye Doctor _____

Name _____ Date of examination _____

Address _____

Notes: _____

_____

_____

_____

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