Cincinnati Association for the
Blind & Visually Impaired

**2045 Gilbert Avenue, Cincinnati, Ohio 45202 • Phone: 513-221-8558 • Fax: 513-221-2995**

# 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 | _____ | _____ |

**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 AND 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: _____

_____

_____

_____