2045 Gilbert Avenue, Cincinnati, Ohio 45202 • Phone: 513-221-8558
Fax: 513-221-2995 • referrals@cincyblind.org

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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