PHYSICIAN'S / OPTOMETRIST'S REPORT ON EYE EXAMINATION

State Form 12417 (R4 / 6-96) OMPP 0045

The information requested on this form is needed to determine eligibility for public assistance and will be treated as a CONFIDENTIAL record according to 470 IAC 1-2-7 and 470 IAC 1-3-1.

INSTRUCTIONS: SECTION I should be completed by the County Office of Family and Children in triplicate. Forward three (3) copies to the examining physician or optometrist.

SECTION I - SOCIAL HISTORY

Name	Date of birth *(month, day, year)*	Sex	Case number

Address *(street, city, state)*	ZIP code	County

Severe ocular infections, injuries, eye operations, if any, with age or time of occurence

Is the client's eye condition believed to have occurred in any blood relatives? ☐ Yes ☐ No	If Yes, what relationship?	Has the client ever had kidney disease, high blood pressure, hardening of the arteries or diabetes? ☐ Yes ☐ No

INSTRUCTIONS: Eye Physician or Optometrist should complete SECTIONS II, III, IV and V. keep one (1) copy and return original and one (1) copy to the County Office, Division of Family and Children.

SECTION II - CAUSE OF BLINDNESS OR VISUAL IMPAIRMENT

	O.D.	O.S.
A. Physical examination of the eyes. Present ocular condition(s) responsible for vision impairment. *(If more than one, specify all but underline the one which probably caused severe vision impairment.)*		
B. Preceding ocular condition, if any, which led to present condition or the underlined condition specified in A.	O.D.	O.S.
C. Etiology *(underlying cause)* of ocular condition primarily responsible for vision impairment *(e.g., specific disease, injury, poisoning, heredity or other prenatal influence.)*	O.D.	O.S.

D. If etiology is injury or poisoning, indicate circumstances and kind of object or poison involved.

E. Has patient had any nonocular disease, not specified, which could have contributed to the visual impairment? ☐ Yes ☐ No	If Yes, specify
Tension *(if glaucoma)*	Instrument used
O.D. MM. Hg. O.S. MM. Hg.	

SECTION III - VISUAL DATA

Central Visual Acuity	Distance (20 ft.)	Distance (20 ft.)
Without Glasses	O.D.	O.S.
With Present Glasses	O.D.	O.S.
With Best Possible Correction	O.D.	O.S.

Refraction Record - To be recorded in all cases where refraction improves visual acuity to better than 20/200.

Sphere	O.D.	O.S.
Cylinder	O.D.	O.S.
Axis	O.D.	O.S.
Bifocal Add	O.D.	O.S.

Field Construction

Is visual field constricted?	If Yes, to what degree?
O.D. ☐ Yes ☐ No	
O.S. ☐ Yes ☐ No	If Yes, to what degree?

SECTION IV - PROGNOSIS AND RECOMMENDATION

A. Does the patient now have suitable glasses? ☐ Yes ☐ No

If No, do you recommend new glasses? ☐ Yes ☐ No

B. Patient's vision impairment is considered to be: ☐ Stable ☐ Deteriorating ☐ Uncertain

C. Will vision improve with treatment? ☐ Yes ☐ No

If Yes, to what degree?

D. Your recommendation

E. If cataracts are the cause of deteriorated vision, state light projection and separation

F. Is re-examination advised? ☐ Yes ☐ No

If Yes, interval?

G. Should there be a referral? ☐ Yes ☐ No

SECTION V - CERTIFICATION

I certify that I have examined this patient and the fee submitted on the attached claim is lawfully due me.

Date of examination *(month, day, year)*	Signature of eye physician or optometrist
Date report completed *(month, day, year)*	Typed or printed name

Address *(street, city, state)*	ZIP code

PLEASE MAKE NO ENTRY BELOW THIS LINE

SECTION VI - DECISION OF SUPERVISING PHYSICIAN

1. From the evidence submitted, the applicant or recipient: ☐ is blind ☐ is not blind

Additional information is required regarding:

2. If the person is blind:

☐ No re-examination is required

☐ A re-examination is required in:
☐ 3 years ☐ 1 year ☐ 3 months
☐ 2 years ☐ 6 months

Comments

Signature of supervising physician	Date signed *(month, day, year)*