**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**MEDICAL REVIEW TEAM (MRT)**
**PHYSICIAN'S REPORT ON EYE EXAMINATION**

MA ID Number/Pending Medicaid Number: _____

Patient's Name: _____ Date of Birth: _____
Street Address: _____
City / State / Zip: _____ Age at onset of blindness: _____
Sex: ☐ Male ☐ Female Race: _____

**Diagnosis** (See Note 1)

Eye condition primarily responsible for blindness: _____

Secondary conditions, if any: _____

Etiological factor responsible for primary eye condition: Right _____
Left _____

**Ocular Motility:** _____

**Nerve Heads** (Describe nerve heads and vessels emerging from nerve heads): _____

**Status of Corneal:** ☐ Clear ☐ Cloudy

**Central Vision** (Use Snelien notations, 20/200, 10/200, 14/140, 14/280, etc., if possible – See Note 2.

| | Without Glasses | | With Glasses | |
|---|---|---|---|---|
| | Distance (20 ft.) | Near (14 in.) | Distance (20 ft.) | Near (14 in.) |
| Right Eye | | | | |
| Left Eye | | | | |

**Peripheral Vision** (See Note 3)

Is there any limitation in the field of vision? ☐ Yes ☐ No If so, indicate the best vision obtainable for each quadrant. Test each quadrant with ophthalmoscope (head detached) to see at what distance light can be seen. Attach field chart if available, noting radius of perimeter, size of test object and illumination.

**NOTE 1:** State separately the eye affection causing blindness, secondary or complicating conditions, and the underlying etiological factor which is responsible for the primary eye affection. Examples: Keratoconjunctivitis, secondary atrophy of globe-ophthalmia neonatorum, gonorrheal, buphthalmos-prenatal syphilitic infection; cataract-diabetes; retinitis pigmentosa-herediatry; irido cycitis, secondary cataract-focual sepsis. In traumatic cases, describe circumstances of accident fully; if industrial accident, give nature of industry.

In the event of a hazy cornea, indicate the location. Is there any part of the cornea normal?

**NOTE 2:** Measurements will be assumed to be stated in the Sneilen formula (either feet or inches) unless otherwise noted. If exact measurements of central vision cannot be given, describe the test used so as to indicate the distance and the size of the test object. Examples: Counts fingers at three feet; hand movement at three feet; light perception only.

**NOTE 3:** Tests should be made with patient fixing one eye on a point three feet straight ahead and with objects held at a distance of three feet from the fixation point in the quadrant of the field under examination, the other eye to be kept closed or covered.

**Please use Page Three for recording re-examinations, operations, treatment, etc.**

**Peripheral Vision With Hand Motion:** O.D. _____ O.S. _____

**Prognosis and Recommendations for Eye Care and Treatments**

Is there any likelihood that vision could be restored or improved by operation or treatment?
☐ Yes ☐ No

Prognosis: _____

Recommendations _____

_____

Remarks: _____

_____

Examination Date: _____ Eye Physician Signature: _____

Date of Report: _____ Address: _____

## HISTORY OF EYE INJURY

Name: _____ Date of Accident: _____
Address: _____

Which eye injured? ☐ Right ☐ Left ☐ Both Age when accident occurred: _____

What was the nature of the accident; was there a perforating injury; was the eye cut? Describe in detail.

_____

_____

_____

What was individual doing when the injury occurred; cutting with scissors; using knife, hammering, filing, chopping wood, etc. If an automobile accident, state whether injury was from broken glass, splinters, a blow. Describe in detail: _____

_____

Was any operation performed? ☐ Yes ☐ No _____

Was there any sight remaining in the injured eye after the accident? ☐ Yes ☐ No _____

When did the injured eye become blind? _____

If the injured eye was totally blind, did the doctor advise removing it? ☐ Yes ☐ No

Was the injured eye, if sightless, removed? ☐ Yes ☐ No Date: _____

## HISTORY OF THE BETTER EYE

How soon did the sight in the **better** eye begin to disappear? _____

How soon after it became affected was an eye specialist consulted? _____

What was his advice? _____

When did the **better** eye become blind? _____

Please give any further details in connection with the accident:

_____

_____

_____

_____

Date of Report: _____ Signature of Eye Physician: _____

## RE-EXAMINATIONS

| Date | Best Corrected Vision | | Changes in Eye Condition | Recommendations (Further examination of treatment – Specify) | Optometrist's Signature |
|---|---|---|---|---|---|
| | Right Eye | Left Eye | | | |
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