



Patient Name: _____ DOB: _____

Patient Phone: _____ Referral Date: _____

Medical Insurance/Member ID: _____

Referring Doctor: _____

Practice Location: _____

Appointment Made

Date: _____

Please Call Patient To Schedule Appointment

Glaucoma History: (First diagnosed, treatment history, progression, etc.)

Current Clinical Findings:

BCVA: R 20/____ IOP: R ____
L 20/____ L ____

Current Meds: _____ OD OS
Current Meds: _____ OD OS
Current Meds: _____ OD OS

Pertinent Slit Lamp/Fundus Findings:

C/D _____ OD _____ OS

Visual Fields: OD Normal Abnormal* _____
OS Normal Abnormal* _____

*Please attach last VF if abnormal

Recommendation for SLT: OD OS

- Reason: Primary treatment
- Suspected patient non-compliance with medication
- Patient desire to reduce dependency on medication
- Patient inability to administer medication
- Patient not adequately controlled with maximal medical therapy
- Expense of medication
- Other (please explain): _____

Primary Diagnosis: POAG Low Tension OHT Pigmentary Other: _____

Glaucoma Stage (required): Mild Moderate Severe

Comments:

Please fax this form to our Referral Concierge: Fax: 317.579.7435 / Ph: 317.841.2028