Eye Surgeons of Indiana

Same Day SLT Referral Form

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

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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