Glaucoma Consultants

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Ophthalmology • Practice Limited to Glaucoma

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Referring Doctor ______ Phone # ______

Address ______

Date of Exam ______

Patient's Name ______

Patient's Phone Number ______

Date of Birth ______

REASON FOR CONSULTATION

_____ Glaucoma

_____ Glaucoma Suspect

_____ Ocular Hypertension

_____ Narrow Angles

_____ NVG

_____ Other (please specify): ______

CURRENT CLINICAL FINDINGS

VA OD ______
OS ______

Refraction OD ______
OS ______

IOP OD ______ mm Hg OS ______ mm Hg Time: ______ am/pm

(circle one: Non-contact; Applanation)

Other Significant Findings: ______

Testing Performed (*please include results*): ______

Testing Requested (*for visual fields, please indicate working diagnosis*) ______

A copy of all test results will be sent to referring doctor.