Glaucoma Consultants

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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_____ Refraction OD_____
OS_____ OS

IOP OD_____mm Hg OS_____mm Hg Time:_____

(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.