

# Glaucoma Referral Request

*Please print.*

Patient Name:	Date of Birth:
Phone:	
Referring Provider:	Phone:

Please schedule a glaucoma referral with Tarra W. Millender, M.D.

**Reason for referral:**

Glaucoma suspect       SLT/surgery       OAG management evaluation  
 Narrow angle evaluation       Cataract/glaucoma evaluation  
 Other (please specify) \_\_\_\_\_

**Please provide the following information, if known:**

Pretreatment pressure OD: \_\_\_\_\_ OS: \_\_\_\_\_ Date: \_\_\_\_\_  
 Diurnal curve readings OD: \_\_\_\_\_ OS: \_\_\_\_\_ Date: \_\_\_\_\_  
 Most recent IOP      OD: \_\_\_\_\_ OS: \_\_\_\_\_ Date: \_\_\_\_\_  
 CCT      OD: \_\_\_\_\_ OS: \_\_\_\_\_ Date: \_\_\_\_\_

**Current eye drop medications and Sig:** \_\_\_\_\_  
 \_\_\_\_\_

**Eye drop intolerances:** \_\_\_\_\_

**List ocular surgeries/lasers:**

Procedure: \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_

**Please send relevant imaging:** HVF(s) OCT(s)

**Additional concerns:** \_\_\_\_\_

Thank you for your assistance. Please fax requested information to (910) 255-2077.