Glaucoma Referral Request

Please print all information.

Patient Name:	Date of Birth:
Address:	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.**