Glaucoma Referral Request

Please print all information.

Patient name:	Date of birth:
Address:	Phone:
Referring Provider:	Phone:

Please schedule a glaucoma referral with (circle one): Garris Millender Messner Sharpe Grissom

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 send the requested information via fax to **(910) 295-5339.**