

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

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**.