Glaucoma Surgery Referral

For treatment available at our Bellingham office

Pacific CATARACT AND LASER INSTITUTE

REFERRING DOCTOR

Name _____

Address _____

_____

Phone (_____) _____

Date of Referral _____

PATIENT INFORMATION

Name _____

Address _____

_____

Phone: Hm (_____) _____ Wk (_____) _____

Date of Birth _____

Procedure desired: ☐ SLT ☐ Micro invasive glaucoma surgery (MIGS, which includes iStent) at the time of cataract surgery

Glaucoma type: (PXE, NAG, POAG, etc.) _____

GLAUCOMA STATUS	**OD**	**OS**
IOP (highest known applanation)	_____ mm Hg	_____ mm Hg
IOP (current applanation with treatment)	_____ mm Hg	_____ mm Hg
Visual fields	☐ Stable ☐ Progressive	☐ Stable ☐ Progressive
Optic nerve imaging	☐ Stable ☐ Progressive	☐ Stable ☐ Progressive

Please include copies of visual fields and optic nerve analysis.

- ☐ Copies are enclosed
- ☐ I am sending them electronically
- ☐ I am sending them via separate mail
- ☐ I have no visual fields or optic nerve analysis studies

Current glaucoma medications _____

Previous glaucoma procedures _____

Comments or additional findings _____

_____

_____

Signed _____
Referring Doctor