

Glaucoma Surgery Referral

For treatment available at our Kennewick office



REFERRING DOCTOR

Name _____

Address _____

Phone (____) _____

Date of Referral _____

PATIENT INFORMATION

Name _____

Address _____

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

Date of Birth _____

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

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