DIAGNOSTIC EYE CENTER

Optometric Glaucoma Consultation

Date: _____ □ Initial Exam □ Annual Exam □ Change in Meds

Patient Name: _____ **DOB:** _____

Medication(s): _____ □ OD □ OS □ OU

Initial IOP: OD: _____ OS: _____

Today's IOP: OD: _____ OS: _____ (if follow up visit)

Target IOP: OD: _____ OS: _____

C/D Ratio: OD: _____ OS: _____

Visual Field Interpretation:

OD: _____

OS: _____

Treatment Plan: _____

_____

Optometrist Info:

Signature: _____

Printed Name: _____

Phone: _____ Fax: _____

I confirm the diagnosis of glaucoma and have reviewed and agree with the above treatment plan.

□ Marc R. Sanders, M.D.

_____ □ Andrew K. Salem, M.D.

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