



# 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.