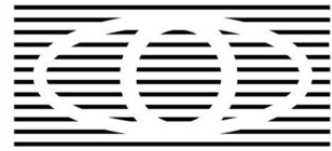


# Glaucoma Treatment Plan



**TURNER EYE INSTITUTE**

MEDICAL GROUP, INC.

800-339-2733

[www.turnereye.com](http://www.turnereye.com)

San Leandro San Francisco San Jose Concord

Referring Dr. \_\_\_\_\_

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Phone \_\_\_\_\_

DOB \_\_\_\_\_

## To Be Completed By Optometrist

Provisional Diagnosis \_\_\_\_\_

Visual Fields (enclosed) \_\_\_\_\_

Intraocular Pressures: R \_\_\_\_\_ L \_\_\_\_\_ Time \_\_\_\_\_ Instrument \_\_\_\_\_

Target Intraocular Pressures: R \_\_\_\_\_ L \_\_\_\_\_

Optic Nerve Head: R: C/D L: C/D R:  L: 

Additional Testing: \_\_\_\_\_

Family Eye History: \_\_\_\_\_

Medical History: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Initial Proposal for Therapy: \_\_\_\_\_

Medication #1: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication #2: \_\_\_\_\_ Frequency \_\_\_\_\_

(Patient will schedule ophthalmological consult)

Additional Comments: \_\_\_\_\_

To Be Completed By Collaborating Ophthalmologist

Results of Physical Exam: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provisional Diagnosis: Confirmed  Refuted

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Proposed Treatment Plan: Approved  Denied

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

To comply with California State Law, please return this form within 30 days:

Fax: \_\_\_\_\_

Or mail: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have questions, please call: \_\_\_\_\_