Glaucoma Treatment Plan

TURNER EYE INSTITUTE
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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: _____