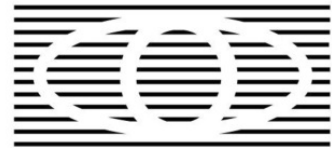


Glaucoma Treatment Plan



TURNER EYE INSTITUTE

MEDICAL GROUP, INC.

800-339-2733

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: _____