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: ____

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____

Provisional Diagnosis: Confirmed ☐ Refuted ☐

Comments: ____

____

____

Proposed Treatment Plan: Approved ☐ Denied ☐

Comments: ____

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____

Signed: ______________________________ Date: ____________________

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

Fax:________________________

Or mail: ________________________

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If you have questions, please call: ______________________