GLAUCOMA PROCEDURES CONSULT FORM

Patient Name: _______________________________________ DOB: ____________________
Referring Doctor: _____________________________________ Date: ____________________

Diagnosis: ____
Current glaucoma treatment: ____

Please check all that apply:

- ☐ IOP above target (OD / OS / OU)
- ☐ Documented ONH C/D progression (OD / OS / OU)
- ☐ Documented HVF defects (OD / OS / OU)
- ☐ Documented ONH OCT defects (OD / OS / OU)
- ☐ High risk for progressive glaucoma (OD / OS / OU)

- ☐ Chronic ocular surface disease
- ☐ Topical medicamentosa to glaucoma medications
- ☐ Systemic contraindications to glaucoma medications
- ☐ Maximum tolerated topical treatment

- ☐ Noncompliance with prescribed glaucoma treatment
- ☐ Noncompliance with glaucoma follow-up appointments
- ☐ Financial Issues/Insurance limitations, unable to afford prescribed treatment
- ☐ Physical difficulty with instillation of topical treatment (tremor, arthritis, etc.)
- ☐ Poor systemic health causing difficulty in frequent follow-ups
- ☐ Patient relies on family/others to instill topical treatment
- ☐ Decreased mental capacity
- ☐ Monocular patient

Notes:____
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Please Fax to: (731) 664-2903 or email to: welcome@hugheseye.com