GLAUCOMA CONSULTATION REPORT – FORM B
(Please send the supporting documentation with this form)

Case#_____ New glaucoma patient___ Established glaucoma patient with change __ no change in treatment__

Date of Consultation:__________________________

Findings:______________________________________________________________
______________________________________________________________
______________________________________________________________

O.D. Diagnosis: ____________________________________________________________________

D.O./M.D. Diagnosis:________________________________________________________________

O.D. Proposed Treatment Plan: ____________________________________________________________________
______________________________________________________________
______________________________________________________________

Mutually Agreed Upon Plan: ____________________________________________________________________
______________________________________________________________
______________________________________________________________

We, the undersigned, certify that the above information is accurate and true to the best of our knowledge. We have the required authorization from the above patient, (or the parent/guardian if a minor), to release this and any other related information requested by the Glaucoma Consultation Committee to meet the requirements of 32 MSRA, Sec-A.

__________________________________, O.D. Date:_______________________
__________________________________, M.D./D.O. Date:_______________________

NOTE: MD signature is not required on this form if a detailed signed letter is presented with supporting documentation.

Revised 12/2002