For Subcommittee use:
Approved by: Initials: ___ Date: _________

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