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

GLAUCOMA CONSULTATION REPORTING – FORM A

Comanaging Doctor's Names:_____, O.D.

_____, M.D./D.O.

This form is being submitted to fulfill the following requirement:

> Retrospective glaucoma related written referral of this patient suspected of having glaucoma with written confirmation of the diagnosis occurring between July 1, 1995 and the receipt of the advanced therapeutic license. (20 cases or the balance to be glaucoma consultations as noted below.)
>
> **Patient Name:_____**
>
> **Date of Consultation:_____**
>
> **O.D's Advanced Therapeutic License Date:_____**

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:_____