For Subcommittee use:

Approved by: Initials : ___ Date:_________

GLAUCOMA CONSULTATION REPORT – FORMB

(*This form does not need supporting documentation*)

______________________________ O.D.

______________________________ M.D./D.O.

Case#___ New glaucoma patient ___ Established glaucoma patient with change __
No change in treatment__

OD exam date________

Pertinent Hx:____
____
____

	OD	OS
VA	_____________	_____________
IOP	_____________	_____________
C/D	_____________	_____________
Gonio	_____________	_____________
Ant Seg	_____________	_____________
VF	_____________	_____________
Dx	_____________	_____________
Previous Tx Plan	_____________	_____________
(for estab. glaucoma pat.)	_____________	_____________
New Tx Plan	_____________	_____________
(as proposed by OD)	_____________	_____________
Date of MD/DO exam	_____________	

Mutually agreed upon Tx plan:

OD	OS
____________	____________
____________	____________

Additional comments:____
____
____

O.D. Signature:________________________________Date:_________

M.D./D.O. Signature:___________________________Date:_________

Revised 12/2002