SLT CONSULT REQUEST

SightLine Ophthalmic Associates
Phone 724-933-5588 • Fax 724-933-6051

PATIENT NAME ________________________________

DATE OF BIRTH ________________________________

REFERRING DOCTOR ____________________________

DATE OF EXAM ________________________________

☐ I have scheduled an appointment for this patient on:

____

☐ I would like Sightline to call this patient to schedule:

PATIENT PHONE ________________________

GLAUCOMA HISTORY: (First diagnosed, Tx Hx, Progression, Changes, Present Field Loss)

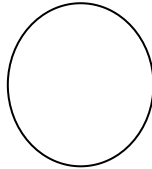
CURRENT CLINICAL FINDINGS:

ccVA: R 20/_______ IOP: R ___________ Current Meds: _______________________________

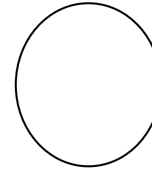
L 20/_______ L ___________ ____

SLIT LAMP:

FUNDUS: (diagram disc)



C/D __________



C/D __________

RECOMMENDATION FOR SLT: ☐ OD ☐ OS

REASON:
- ☐ Primary Treatment
- ☐ Suspected patient non-compliance with medication
- ☐ Patient desire to reduce dependency on medication
- ☐ Patient inability to administer medication
- ☐ Patient not adequately controlled with maximum medication
- ☐ Expense of medication
- ☐ Other (please explain): ____________________________________

PRIMARY DIAGNOSIS: ☐ POAG ☐ Low Tension ☐ OHT ☐ Pigmentary ☐ Other: ______________________

GLAUCOMA STAGE *(required)*: ☐ Mild (365.71) ☐ Moderate (365.72) ☐ Severe (365.73)

______ Report Faxed to SightLine

Signature ____________________________________