SLT CONSULT REQUEST

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

PATIENT NAME _____ □ I have scheduled an appointment for this patient on:

DATE OF BIRTH _____ _____

REFERRING DOCTOR _____ □ I would like Sightline to call this patient to schedule:

DATE OF EXAM _____ PATIENT PHONE _____

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

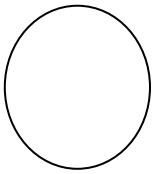
CURRENT CLINICAL FINDINGS:

ccVA: R 20/_____ IOP: R _____ Current Meds: _____

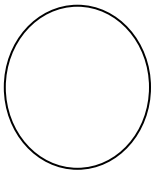
L 20/_____ L _____ _____

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 ☐ Moderate ☐ Severe

_____ Report Faxed to SightLine Signature _____