SLT CONSULT REQUEST

Cataract and Eye Consultants
Phone 724-617-2020 • Fax 724-453-4108

PATIENT NAME _____

DATE OF BIRTH _____

REFERRING DOCTOR _____

DATE OF EXAM _____

Please send a copy of the current insurance card + photo ID for direct scheduling of procedure

CEC will call this patient to schedule:

PATIENT PHONE _____

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

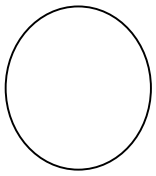
CURRENT CLINICAL FINDINGS:

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

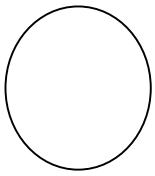
L 20/_____ L _____ _____

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 ☐ Moderate ☐ Severe

_____ date report faxed to CEC

Signature _____