



Glaucoma Patient Referral

Date: _____

Referring Doctor's Name (Print): _____

Referring Doctor's Address (Print): _____

Phone: _____ Fax: _____

Contact Email: _____

Patient's Name: _____ Phone: _____ DOB: _____

Records being sent: Fields -- Nerve Scans -- IOP history -- Medication Hx (include specifics)

(Note: Please mail color data such as OCT scans and other materials that do not fax well. The patient can hand deliver the color data if needed, yet receipt of records before the patient visit will expedite the consultation and treatment plans. For emergency consultations, please call directly and ask our doctor to be interrupted).

Please check your doctor preference:

- Teresa Carlson, OD Tom Cruse, OD Isha Gupta, MD Robert Prouty, OD Richard Stewart, MD
- Carl Tubbs, MD *First Available*

Reason for Referral (Please be specific: IOP too high? vision loss? OAG suspect? Surgery needed?):

Coordination of Glaucoma care:

- One-time consult Diagnose and treat this problem Co-manage
- Transfer complete management I will follow for routine care only Other

For testing only, please indicate desired testing:

Visual Fields: HFV 24-2 - HVF 10-2 - SWAP

Nerve Fiber Analysis: Cirrus (Zeiss) or Avanti (OptoVue) OCT of ONH & macula scan (GCC)

Other: Avanti Angle OCT Scan - Digital fundus photos – Immersion A-scan – IOL master
 High Resolution B-scan – Endothelial Cell Count – Pentacam

Parker P: 303.794.1111 F: 303.347.1341 Lowry P :303.671.0000 F: 303.671.2879
Boulder P: 303.402.1000 F: 303.593.2199 Longmont P: 303.485.1516 F: 303.776.1110
Fort Collins P: 303.485.1516 F: 303.776.1110