

Glaucoma Patient Referral



INSIGHT VISION GROUP

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 or email color data such as OCT scans and other materials that do not fax well—receipt of records before 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:

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 - Goldmann
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 – Visante OCT

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 Lakewood ~ P:303.794.1111 F: 303.347.1341