INSIGHT VISION GROUP

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:

☐Robert Prouty, OD ☐Richard Stewart, MD ☐Carl Tubbs, MD ☐Teresa Carlson, OD ☐Tom Cruse, OD

☐*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