

GLAUCOMA CONSULTATION REQUEST

Thank you for requesting a consultation with the UK Ophthalmology Glaucoma service:
Sheila Sanders, MD and Daniel Moore, MD.

In order to provide the best possible care and help us prioritize patient scheduling, please provide as much information as possible below.

PLEASE SEND THE FOLLOWING WITH THIS FORM (if available):

RECENT CLINICAL NOTES
VISUAL FIELDS
BASELINE AND RECENT OCT SCANS

This information can be faxed to Susan at **859-257-6718** or email: **snfu225@uky.edu**

UK Department of Ophthalmology will contact your office via fax or telephone with patient's scheduled appointment. We may ask that you contact patient with the appointment since sometimes the patient does not understand why they need to come to UK. Please note all new patients will be mailed a new patient welcome letter that includes their appointment date, time and map to our office.

Today's Date _____ Patient's SSN _____

Patient's name _____ Sex: _____ DOB _____

Home Telephone _____ Cell _____

Mailing Address _____

City _____ State _____ Zip Code _____

Insurance Information _____

URGENCY	_____ Emergency (<72 hours)	_____ Urgent (4-14 days)	_____ Routine
CONCERNS	_____ Possible glaucoma	_____ Progressing glaucoma	_____ Narrow Angle
	_____ Surgical consultation	_____ Cataract evaluation	_____ Other
REQUESTING	_____ Consultation only	_____ Consult & Testing	_____ Consult & Treat
	_____ Ongoing co-management	_____ Transfer of care	_____ Test Only

Clinical History: Vision OD _____ Vision OS _____

MRx or Wearing _____

Pre Treatment or Max IOP: OD _____ OS _____ Current IOP: OD _____ OS _____

All current Meds _____

Previous Meds _____

Any previous eye lasers, surgeries, or trauma _____

Significant systemic disease's _____

Any other specific concerns or key info _____

Please Print Referring Provider Name & Complete Address: _____

Your Telephone _____ Your Fax _____