HealthCare
Advanced Eye Care

Office Telephone 859-323-5875

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 Telelphone_____ 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 _____