

# 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 \_\_\_\_\_

<b>URGENCY</b>	<input type="checkbox"/> Emergency (<72 hours)	<input type="checkbox"/> Urgent (4-14 days)	<input type="checkbox"/> Routine
<b>CONCERNS</b>	<input type="checkbox"/> Possible glaucoma	<input type="checkbox"/> Progressing glaucoma	<input type="checkbox"/> Narrow Angle
	<input type="checkbox"/> Surgical consultation	<input type="checkbox"/> Cataract evaluation	<input type="checkbox"/> Other
<b>REQUESTING</b>	<input type="checkbox"/> Consultation only	<input type="checkbox"/> Consult & Testing	<input type="checkbox"/> Consult & Treat
	<input type="checkbox"/> Ongoing co-management	<input type="checkbox"/> Transfer of care	<input type="checkbox"/> 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 \_\_\_\_\_