GEM CLINIC
Est. 2011

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Glaucoma Referral Form

Patient Full Name:	**DOB:**	**PHIN:**
Referral Date:	**Referring Doctor:**	

Reason for Glaucoma Referral (choose one):

- ◯ glaucoma suspect
- ◯ narrow-angle assessment
- ◯ patient lost to follow-up
- ◯ elevated IOP - prefer laser
- ◯ POAG/OHT/OAG - uncontrolled
- ◯ glaucoma progression

Urgent Symptoms: Does the patient have any of the following urgent symptoms?

intense eye pain for ____ days ____ weeks and/or ◯ rapid loss of vision

Glaucoma Progression - Has glaucoma progression been identified?

◯ Yes (e.g. worsening visual field, worse OCT/CD ratio, increased vision loss)
◯ No

Intraocular Pressure (IOP) - What is the patient's IOP level by applanation?

◯ pre-treatment, if available: _____ mmHg ◯ highest recorded IOP (Tmax): _____ mmHg

Glaucoma Stage - In what stage is the glaucoma?

◯ advanced ◯ moderate ◯ early ◯ unknown

Ocular drops, if any:

Allergies to previous treatments?: ◯ No ◯ unknown
◯ if yes, describe:

Previous ocular treatments/dates?

Patient Tests: ◯ serial VFs attached ◯ OCT attached ◯ OCT to be mailed

Additional Comments (if any):

Thank you for filling out this form to help us triage for timely patient care.