



Glaucoma Patient Referral

Date: _____

Referring Doctor's Name (Print): _____

Referring Doctor's Address (Print): _____

Phone: _____ Fax: _____ Email: _____

Patient's Name: _____ Phone: _____ DOB: _____

Insurance: _____ Member ID: _____

Group Number: _____ Phone number for Providers : _____

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: *First Available*

Lone Tree, Arvada, Denver Teresa Carlson, OD Tom Cruse, OD

Katie Goldhair, MD Stephanie Muylaert, MD

Boulder, Longmont Heather Gitchell, OD Shipra Gupta, MD Richard Stewart, MD

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

Lone Tree, Arvada and Denver Yale - P: 720.458.4013 F: 720.306.5411

Boulder and Longmont - P: 303.402.1000 F: 303.593.2199