



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Medical Insurance/Member ID: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Practice Location: \_\_\_\_\_

Preferred Office:  Indianapolis  Lafayette

**Appointment Made**  
 Date: \_\_\_\_\_  
 **Please Call Patient To Schedule Appointment**

**Glaucoma History:** (First diagnosed, treatment history, progression, etc.)

**Current Clinical Findings:**

BCVA: OD 20/\_\_\_\_ IOP: OD \_\_\_\_  
OS 20/\_\_\_\_ OS \_\_\_\_

Current Meds: \_\_\_\_\_  OD  OS  
Current Meds: \_\_\_\_\_  OD  OS  
Current Meds: \_\_\_\_\_  OD  OS

Pertinent Slit Lamp/Fundus Findings:

C/D \_\_\_\_\_ OD \_\_\_\_\_ OS \_\_\_\_\_

Visual Fields: OD  Normal  Abnormal\* \_\_\_\_\_ \*Please attach last VF if abnormal  
OS  Normal  Abnormal\* \_\_\_\_\_

**Recommendation for SLT:**  OD  OS

- Reason:  Primary treatment
- Suspected patient non-compliance with medication
  - Patient desire to reduce dependency on medication
  - Patient inability to administer medication
  - Patient not adequately controlled with maximal medical therapy
  - Expense of medication
  - Other (please explain): \_\_\_\_\_

**Primary Diagnosis:**  POAG  Low Tension  OHT  Pigmentary  Other: \_\_\_\_\_

**Glaucoma Stage (required):**  Mild  Moderate  Severe

**Comments:**

Please submit completed form to our Referral Concierge by clicking Submit or email to [referrals@esi-in.com](mailto:referrals@esi-in.com)  
Fax: 317.579.7435 | Ph: 317.841.2028 | Email: [referrals@esi-in.com](mailto:referrals@esi-in.com)