Eye Surgeons of Indiana

Same Day SLT Referral Form

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
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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:

SUBMIT

Please fax this form to our Referral Concierge: Fax: 317.579.7435 / Ph: 317.841.2028