Glaucoma Consultation Request

Robert M. Schertzer MD Inc
West Coast Glaucoma

To: Dr. Robert Schertzer, MD, FRCSC
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From: ____________________ Billing #:______________
Address: ____________________________________
Phone: ______________ Fax: ______________
Email: ____________________________________

Patient
Name: ______________________________
Phone #: ______________________________
MSP #: ______________________________
D.O.B. ______________________________
YYYY / MM / DD

To make an appointment, please fax this form to:
(ALL INFO **MUST** BE COMPLETE)

FAX: (604) 873-2937

We triage requests throughout the day; calling does not get your patient in more quickly. We will fax the appt. information to you.

Please provide this patient with the following services (CHECK AT LEAST ONE):

☐ An initial comprehensive glaucoma evaluation
Includes: a thorough medical/surgical history, visual field studies, slit-lamp exam, gonioscopy, dilated fundus exam and optic-nerve images, as appropriate.
My office (referring doctor) will provide: ☐ visual fields ☐ optic-nerve images

☐ This patient is ***not*** being referred for an ophthalmic exam. Please provide:
☐ Visual field studies ☐ HRT and report ☐ Optic-nerve images

☐ Referred-back exam (glaucoma patient co-managed with you). Perform appropriate studies.
My office will provide: ☐ visual fields ☐ optic-nerve images

Clinical History
V_{cc} (far): OD 20 / ____ OS 20 / ____
Refraction: OD _________ OS _________
☐ Suspect, open angle glaucoma ☐ Open angle glaucoma
☐ Suspect, narrow angles ☐ ______________

Date / Time		
IOP OD ☐ A ☐ NCT		
IOP OS ☐ A ☐ NCT		
C / D OD		
C / D OS		

Additional Clinical Notes
(history, meds, surgeries, questions)