EAST BAY EYE CENTER MEDICAL CORPORATION

Todd D. Severin, M.D.
Elliot B. Werner, M.D.

GLAUCOMA REFERRAL FORM

REFERRING PROVIDER:_____O.D. DATE:_____

YOUR PHONE:_____ YOUR FAX:_____

PATIENT NAME:_____ **PHONE (H)**_____

(Work/Cell)_____

VISUAL HISTORY:_____

SIGNIFICANT MEDICAL HISTORY:_____

CURRENT MEDICATIONS:_____

OCULAR MEDICATIONS:_____

_____

BEST VISION

OD_____**=20/**_____

OS_____**=20/**_____

ADD_____

RISK FACTORS

☐ Family History ☐ Race ☐ Age ☐ Heart Disease

☐ HTN ☐ Chronic Steroid Use ☐ Asthma ☐ Allergies

IOP: **OD**_____mmHg **OS**_____mmHg **KPach: OD**_____ **OS**_____

IOP HISTORY:_____

PUPILS:

SLIT LAMP:

DISCS: (please enclose photos if available)

VISUAL FIELDS: (please enclose) OCT (if done): (please enclose)

ASSESSMENT:_____

Plan:

5801 Norris Canyon Road, Suite 200
San Ramon, CA 94583
(925) 830-8823 Fax (925) 866-6610