Health Care Facility: _____
Referring Provider: _____
Address: _____
City, State, Zip: _____
Phone: _____ **Fax**_____

eye clinic of wisconsin™
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Glaucoma Patient Data Sheet

****Please include copy of all visual field testing. If you do not perform visual field testing, check here: _____**

Please also complete this Glaucoma Patient Data Sheet. Incomplete information may result in delayed scheduling.

Date: _____

Patient _____ DOB: _____ is scheduled to see you for a Glaucoma Evaluation.

Patient originally diagnosed with Glaucoma:
_____
Date

Untreated IOP (if known): OD _____ ; OS _____

Most Recent Treated IOP: OD _____ ; OS _____

VCC: OD 20/_____ OS 20/_____

VSC: OD 20/_____OS 20/_____

Current Glaucoma Medical Therapy:

EYE		MEDICATION
OD	OS	
OD	OS	
OD	OS	
OD	OS	

Previous Glaucoma Medical Therapy Used and Response

PREVIOUS MEDICATION	RESPONSE (including side effects/allergic reaction)
Previous Glaucoma Interventions (laser or surgery)	

TYPE	EYE		DATE
	OD	OS	
	OD	OS	
	OD	OS	
	OD	OS	

Other Ocular Procedures:

TYPE	EYE		DATE
	OD	OS	
	OD	OS	
	OD	OS	
	OD	OS	

Please include copies of all Visual Field Tests. Please also complete this Glaucoma Patient Data Sheet. Incomplete information may result in delayed scheduling.

Please fax completed forms to (715) 261-8665 or (715) 261-8671