GLAUCOMA CO-MANAGEMENT PLAN

Record No. ________________

Date _____/_____/_____

Patient's Name ____ DOB _____/_____/_____

Pre-Treatment IOP Range

Dates _____/_____/_____ to _____/_____/_____ OD_____________ to ___________

No. of readings: _________________ OS _____________ to ___________

Gonioscopy Findings

Date _____/_____/_____ OD ______________________________

OS ______________________________

Photos Taken ☐ Yes ☐ No

Date _____/_____/_____

Optic Nerve Evaluation

Date _____/_____/_____ C/D (v/h) OD: ____________ Notching ☐ + ☐ _

OS: Notching ☐ + ☐ _

Visual Field Findings

Date(s) _____/_____/_____ Change from Prior VF

Type of VF ☐ 10-2 ☐ 24-2 ☐ 30-2 ☐ 120pc OD: ________________

☐ Other ________________ ________________

Reliability OD ☐ Good ☐ Fair ☐ Poor OS: ________________

OS ☐ Good ☐ Fair ☐ Poor ________________

Eye Color: _________________________________ Pulse Rate: _________________ bpm

Exam Schedule (e.g., q 4 mos., q 6 mos., q 12 mos., etc.)

Test	**Frequency**	**Performed By**	
Tonometry	_________________	☐ O.D.	☐ M.D.
Visual Field (Type: ______)	_________________	☐ O.D.	☐ M.D.
Optic Nerve Evaluation	_________________	☐ O.D.	☐ M.D.
Gonioscopy	_________________	☐ O.D.	☐ M.D.

Target IOP

OD: ______________

OC:______________

Medication/Treatment Plan

		Frequency
gtts: ______________	☐ OD ☐ OS ☐ OU	______________
gtts: ______________	☐ OD ☐ OS ☐ OU	______________
gtts: ______________	☐ OD ☐ OS ☐ OU	______________

P.O.____________________________________

Compliance: ☐ Good ☐ Fair ☐ Poor

Criteria for surgical intervention: ____

____

Risk Factors

☐ Family History

☐ Blunt Trauma

☐ Age _____ ☐ Sex ___

☐ Race ___________

☐ H/o high IOPs

☐ Previous Ocular Surgery

____

Medical History

☐ Previous dx of glaucoma

Date ___/___/_____

☐ Asthma/COPD/Emphysema

☐ Kidney Stones

☐ Diabetes

☐ Cardiac (CHF, Arrhythmia)

☐ HTN

☐ Neurological

☐ Stroke

☐ Other ________________

____

Allergies to Medication

Sulfur ☐ Yes ☐ No

1. ________________________

2. ________________________

Medications

Ocular

1. ____________________

2. ________________

3. _____________________

Systemic

1. ____________________

2. ____________________

3. _____________________

Signature (OD): ____ Signature (MD): ____

Address: ____ Address: ____

____ ____

License No: ____ License No: ____