GCM
GLAUCOMA CENTER OF MICHIGAN

PATIENT EXAM DATE: _____

PHYSICIAN PREFERENCE

____ NO PREFERENCE
____ LES I. SIEGEL, M.D., F.A.C.S.
____ MATTHEW E. CITRON, D.O., F.A.C.S.
____ MICHAEL J. SIEGEL, M.D., F.A.C.S.
____ FAISAL Y. RIDHA AL-TIMIMI, M.D.
____ SONIA W. RANA, M.D.

_____GLAUCOMA AND / OR _____CATARACT EVALUATION

Patient Name:_____
Address:_____
_____
Phone #_____

Referring Doctor Name:_____
Address_____
_____
Phone #_____ **Fax #**_____

_____THE APPOINTMENT IS SCHEDULED FOR _____

_____PATIENT WILL CALL FOR AN APPOINTMENT _____GCM WILL CALL TO SCHEDULE APPOINTMENT

GLAUCOMA EVALUATION

___Ocular Hypertension
___Open Angle Glaucoma
___High Intraocular Pressure
___Suspicious Cup to Disc Ratio
___Narrow Angle Glaucoma
___Other_____

CATARACT EVALUATION _____ **CO-MANAGEMENT** ___YES ___NO

Visual Needs:
(Check the patient's primary interest)

NEAR	INTERMEDIATE	DISTANCE
___Fine Print	___Computer	___Golf
___Sewing	___DiningTable/Cooking	___Driving
___Phone Book	___Playing Cards	___Movies/ TV

Patient Priority / Goal: _____Maximize freedom from glasses _____Maximum distance vision

Target Refraction: _____OD _____OS

Patient Interested in: ___Presbyopic IOL ___Bilateral Distance___Monovision

CURRENT EYEGLASS PRESCRIPTION: OD_____OS_____

PERTINENT FINDINGS:_____

_____

_____

THE PATIENT IS BEING REFERRED FOR TESTING ONLY

_____Visual Field _____OCT _____Fundus Photos _____Pachymetry _____Other_____

Please specify diagnosis _____

Top copy for referring office; center copy to patient; fold & return bottom copy using mailing label on back or fax to 248-356-0424

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