



WHATCOM EYE SURGEONS

A Division of Northwest Eye Surgeons of Seattle

Glaucoma Consultation Request Form

For severely increased eye pressures, please call our office directly at 800-826-4631

Date of Referral: ____/____/____

Patient's Name: _____ Date of Birth: ____/____/____

Patient's Cell Phone: _____ Preferred method of contact: ☐ Phone ☐ Text ☐ Email

Patient's Home Phone: _____ Patient Email: _____

Glaucoma Status

Reason for referral:

☐ Glaucoma surgery/laser ☐ Glaucoma, suspect or medical ☐ Narrow angle/PI laser

****Please attach any current chart notes, and last 3 or more years of visual fields and imaging****

Pretreatment and highest known pressures: _____ Most recent IOP/range: _____

Current glaucoma medications: _____

Pertinent history/risk factors (trauma, ocular surgeries/procedures, FHx, medical Hx, steroid use, etc.):

Consulting Whatcom Eye Surgeons' Physician: _____

Okay to schedule with a different WES provider if available sooner? ☐ Yes ☐ No

Glaucoma Post Consultation Care:

- ☐ Consultation, second opinion: patient wishes to return to my office for glaucoma management.
- ☐ Glaucoma consultation and management requested at WES, comprehensive eye care at my office.

Your Information

Referring Doctor: _____ Practice: _____

Address: _____

Phone: _____ Fax: _____

Please fax to Whatcom Eye Surgeons (360) 676-6298.