ASCEND EYE CENTER
ADVANCED EYE CARE & SURGERY

755 Highland Oaks Drive, Ste 202
Winston Salem, NC 27103

Phone (336) 997-4599
www.ascendeye.com

Referring Provider________________________________Referral Date______________

Referring Office Phone________________________ Office Fax____________________

Patient Name.(Last, First)_________________________ Date of birth______________

Home Address____ Age _______

City__________________________State________ Zip Code____________ Gender M F

Home Phone____________________Email_____________________________________

Cell Phone_____________________ Insurance Carrier___________________________

Please check desired time frame

Urgent (within 2 weeks)
Expedited (within 1 month)
Next available
Other ____________________

Reason for consult

Evaluate for appropriate management
Evaluate for laser treatment
Evaluate for surgical treatment
Second opinion
Other ____________________

Scope of Consultation

Consult 1: Evaluation, management, and complete follow-up
Consult 2: Evaluation, management, and acute follow-up
Consult 3: Evaluation, management, and shared follow-up
Consult 4: Evaluation and recommendations only
Consult 5: According to consultant's preference

Diagnosis

Glaucoma suspect
Ocular hypertension
Narrow angles
Open angle glaucoma
Chronic angle closure glaucoma
Neovascular glaucoma
Pseudoexfoliation glaucoma
Uveitic glaucoma
Unknown
Other ____________________

Glaucoma Status	OD (Right eye)		OS (Left eye)	
IOP (max known)	______ mmHg		______ mmHg	
IOP (current)	______ mmHg		______ mmHg	
Visual fields	Stable	Progressive	Stable	Progressive
Optic Nerve OCT	Stable	Progressive	Stable	Progressive

Please include (1) patient insurance, (2) Visual Fields, and (3) Optic Nerve OCT's

I am sending patient's insurance information
I am sending Visual Fields
I am sending Optic Nerve OCT
I have no visual fields or Optic Nerve OCT studies

Current Medications

____
____
____
____

Medication intolerances

____
____
____
____

Other relevant information____

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Please send records along with this cover sheet to secure digital portal at Scheduling@ascendeye.com
If requesting an urgent consultation, please call (336) 997-4599 to confirm receipt of your request and relay clinical information.

Thank you for referring your patient to Ascend Eye Center