# Robert Schertzer, MD, MEd, FRCSC

## Glaucoma Consult Request

MSP# 26035

Corporate Address:
Dr. Robert Schertzer Inc.
6362 Fraser St, Suite 518
Vancouver, BC V5W 0A1
westcoastglaucoma.com
info@iguy.org

Date of Referral: ______________________

Patient Name: ______________________

PHN: ______________ DOB: ______________ (YYYY / MM / DD)

Patient Phone: ______________________

Patient Email: ______________________

Referred by: ______________ Billing #: ______________

Address: ______________________

Phone: ______________ Fax: ______________

Email: ______________________

Please provide this patient with the following services (CHECK AT LEAST ONE):

☐ An initial comprehensive glaucoma evaluation (includes: a medical history, visual field studies, slit-lamp exam, gonioscopy, dilated fundus exam, optic-nerve images, as appropriate).
My office (referring doctor) will provide: ☐ visual fields ☐ optic-nerve images

☐ Referred-back exam (glaucoma patient co-managed with you). Perform appropriate studies.
My office (referring doctor) will provide: ☐ visual fields ☐ optic-nerve images

To make an appointment, fax this COMPLETED form:

Please select only one office:

☐ **Nanaimo (Tue - Fri)**
**FAX: (250) 753-5422**
c/o Rob Piemontesi, MD
1651 Boundary Ave
Nanaimo, BC V9S 5R8
Ph: (250) 753-8415

☐ **East Vancouver (Mondays)**
**FAX: (604) 876-6557**
c/o Krista Scott, MD
1750 E 10th Ave, Suite 304
Vancouver, BC V5N 5K4
Ph: (604) 876-7433

We triage requests throughout the day; calling does not get your patient in more quickly. We will fax the appt. information to you.

Clinical History

Vcc (far): OD 20 / ________ OS 20 / ________

MRx: OD ______________________

OS ______________________

☐ Suspect, open angle glaucoma ☐ Open angle glaucoma

☐ Suspect, narrow angles ☐ ______________

| Date / Time | | |
|---|---|---|
| IOP OD ☐ A ☐ NCT | mm Hg | mm Hg |
| IOP OS ☐ A ☐ NCT | mm Hg | mm Hg |
| C / D OD | | |
| C / D OS | | |

Additional Clinical Notes
(history, meds, surgeries, questions)