

AMJAD P. KHOKHAR, M.D.

Comprehensive Ophthalmologist
Refractive Surgeon
Board Certified
Fellow, American Academy of Ophthalmology



GLAUCOMA CO-MANAGEMENT FORM

PATIENT _____ DOB _____

DATE OF VISIT _____ Initial Subsequent

MEDICATIONS

Presently _____ Changing to _____

TONOMETRY (Please supply intraocular pressures by applanation)

Initial OD _____ OS _____ Today OD _____ OS _____
Pachymetry OD _____ OS _____ Target OD _____ OS _____

GONIOSCOPY (Please complete 360 degree gonioscopy)

OD: Schwalbe Ant Trab Post Trab Scleral Spur Ciliary Body _____
OS: Schwalbe Ant Trab Post Trab Scleral Spur Ciliary Body _____

VISUAL FIELD (Please comment on protocol, deficits, reliability, and changes)

OD: _____
OS: _____

OPTIC NERVE (Please comment on C:D and appearance)

OD Initial _____ Present _____
OS Initial _____ Present _____

OCT (Please comment on nerve fiber layer thickness))

OD Initial _____ Present _____
OS Initial _____ Present _____

IMPRESSION _____

PLAN _____

Signature _____ Name _____ Phone _____ Fax _____

Please fax this form to 281-240-0479 within 30 days. When this form is faxed back to you, please chart as confirmation of consultation. Thank you. [Rec'd: _____]

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