AMJAD P. KHOKHAR, M.D.
Comprehensive Ophthalmologist
Refractive Surgeon
Board Certified
Fellow, American Academy of Ophthalmology

HOUSTON LASIK & EYE

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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A. Khokhar MD