

PLACE LABEL HERE.  
  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#



1200000

**OPHTHALMOLOGY GLAUCOMA  
FOLLOW-UP VISIT**

2 pt identifiers obtained

Report to: \_\_\_\_\_

CC:  
HPI:

**INTERIM  
MED Hx:  
Systemic MEDS:  
ROS:**

**E** \_\_\_\_\_  
**Y** \_\_\_\_\_  
**E** \_\_\_\_\_  
**M** \_\_\_\_\_  
**E** \_\_\_\_\_  
**D** \_\_\_\_\_  
**S** \_\_\_\_\_

**Va:** CC SC  
**D** RE: \_\_\_\_\_ PH \_\_\_\_\_ **N** RE: \_\_\_\_\_  
LE: \_\_\_\_\_ PH \_\_\_\_\_ LE: \_\_\_\_\_  
**W** RE: \_\_\_\_\_ Add: \_\_\_\_\_  
LE: \_\_\_\_\_ Add: \_\_\_\_\_  
**M** RE: \_\_\_\_\_ Add: \_\_\_\_\_ VA: \_\_\_\_\_  
LE: \_\_\_\_\_ Add: \_\_\_\_\_ VA: \_\_\_\_\_

**T:** App/Pneumo RE: \_\_\_\_\_ at \_\_\_\_\_ **PUPILS:**  
Tono-Pen am/pm  
LE: \_\_\_\_\_ **EOM:**

Dilated with phenylephrine 2.5%  
and tropicamide 1% RE/LE at \_\_\_\_\_ am/pm

**CVF:**

**External:**

**Technician (Name/Signature)**

Physician HPI:

**EOM:** \_\_\_ Full and Conjugate  
\_\_\_ Orthophoric

**CVF:** \_\_\_ FCF x 4 OU  
 **NEURO:** \_\_\_ A&O x 3

- S**
- L**  LLL
- I**  CONJ
- T**  CORNEA
- L**  AC
- A**  IRIS
- M**  LENS
- P** VITREOUS
- F**  DISC
- U**  MACULA
- N** VESSELS
- D** PERIPHERY
- S**

**ASSESSMENT:**

**PLAN:**

\_\_\_\_\_  
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\_\_\_\_\_

**Today:**  SLP  DP  HVF  OCT  
**F/U:**  IOP  MR  GONIO  HVF  DIL

I saw, evaluated patient and agree with findings  
and plan, with add. comments as noted

Resident / Fellow (Signature) PIC Date/Time  
FORM # 100576 CAT: 12-OUTPATIENT ENCOUNTER (ORIG. 05/10)

Attending Physician (Signature) PIC Date/Time  
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