

TONOMETRY REFERRAL FORM

When referring a patient for overnight monitoring or critical care, please phone and fax this form and any pertinent information regarding the patient.

DATE	TIME	EXPECTED PATIENT ARRIVAL TIME
Referring Hospital & Veterinarian		

CLIENT / PATIENT

Client Last Name		First Name	
Street Address		City	Postal Code
Home Phone	Cellular	★ Email	
Species	Breed	Age	Sex M MN F FS
Name			

EYES INVOLVED Right (OD) Left (OS) Both (OU)

IOP measurement only - refer back to RDVM for treatment as needed Tonopen fee only(+ local anesthetic)

IOP measurement with exam and AECFV to treat as needed. If this option is preferred, please complete following information. Tonopen fee in addition to Exam and Treatment fee charged.

RELEVANT HISTORY
OCULAR CONDITIONS AND CLINICAL SIGNS
TENTATIVE DIAGNOSIS / PROGNOSIS / CONCERNS
DIAGNOSTIC TESTS & RESULTS, PREVIOUS OR CURENT MEDICAL PROBLEMS
TREATMENT /MEDICATIONS CURRENTLY OR PREVIOUSLY GIVEN

AECFV veterinarian to choose treatment as required? AECFV veterinarian to treat per your instructions?

If IOP greater than _____ treat with _____

If IOP less than _____ treat with _____

If IOP normal then _____