## OCULAR HYPERTENSION MONITORING SCHEME REPORT

To Dr: _____

Address: _____

_____

Patient Name: _____

Address: _____

_____ Date of Birth: _____

Date of OHTMS Review Appointment: _____ / _____ / _____

Goldman Applanation Tonometry Time: _____ / _____ _____ _____

Anterior Angle Assessment (Van Herick) R Grade: _____ _____

Disc Assessment Comments:

R: C:D _____

L: C:D _____

Threshold Visual Fields Instrument Used:

Right Eye Field ☐ Full

☐ Deficient (send plot to ophthalmology service) Comments:

Left Eye Field ☐ Full

☐ Deficient (send plot to ophthalmology service)

Compliance with Ocular Hypertension Medication (please tick)

☐ This patient is NOT taking any IOP lowering medication

☐ This patient is taking _____ Right Eye ☐ Left Eye ☐ Both Eyes ☐

Comments:

Outcome FOR INFORMATION ONLY

☐ This patient DOES NOT require referral to the Ophthalmology Service and will be reviewed again in 12 months.

☐ This patient HAS BEEN REFERRED to the Ophthalmology service at _____ due to findings and comments above. They have been sent a copy of this report.

☐ This patient's eyes have been unchanged for at least 5 years. They have been discharged from OHTMS with a recommendation for an annual eye examination by their optometrist.

Optometrist Name: _____

Signature: _____

Date: _____ / _____ / _____

Optometrist Address or Stamp:

1. Copy GP ☐ 2. Copy Optometrist ☐ 3. Copy Patient ☐