OCULAR HYPERTENSION MONITORING SCHEME REPORT

To Dr: _____

Address: _____

_____

Patient Name: _____

Address: _____

Postcode: _____ Date of Birth: _____

Date of OHTMS Review Appointment: _____ / _____ / _____

Goldman Applanation Tonometry Time: _____ / _____ hr R: _____ mmHg L: _____ mmHg

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

Disc Assessment Comments:

R: C:D _____

L: C:D _____

Threshold Visual Fields Instrument Used:

Right Eye Field ☐ Full Comments:

☐ Deficient (send plot to HES)

Left Eye Field ☐ Full

☐ Deficient (send plot to HES)

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 Hospital Eye Service and will be reviewed again in 12 months. A reminder will be sent at this time.

☐ This patient HAS BEEN REFERRED to the HES due to findings and comments above. A copy of this report has been sent to _____ Hospital

☐ 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 ☐