



T H E  
WESTCHESTER  
MEDICAL PRACTICE P.C.

**GLAUCOMA SCREENING**

Welcome to the Westchester Medical Practice. You have made an important health decision by showing up for today's glaucoma screening.

Glaucoma is a leading cause of blindness, however if detected and managed early, the effects on vision can be minimized. The most important risk factor for glaucoma is high eye pressure. The purpose of today's screening is to measure your eye pressure.

I hereby authorize the ophthalmologists at The Westchester Medical Practice to conduct an eye pressure check as a screening tool for glaucoma. I understand that even with normal eye pressures, there is a small chance I may still have glaucoma which can only be seen with a more comprehensive examination and additional testing.

I understand that I am here today for an eye pressure screening only and not an ophthalmologic examination. Your vision will not be checked as part of today's screening. If I wish to have a more detailed examination, I will make an appointment to see an ophthalmologist.

I understand that I will receive numbing eye drops(proparacaine) as part of today's screening to adequately measure the eye pressure. Even with this drop there still is a small chance of slight discomfort when measuring eye pressures.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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*For office use only below this line*

\_\_\_\_\_ mmHg OD

Recc: \_\_\_\_\_

IOP

\_\_\_\_\_ mmHg OS

\_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date



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### Patient Information:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Privacy Practices Acknowledgement

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

(Print Name) \_\_\_\_\_

(Sign Name) \_\_\_\_\_

(Date) \_\_\_\_\_