CONFIRMATION OF POSTOPERATIVE COMANAGEMENT
SELECTION BY THE PATIENT

Patient Name: _____

Patient Confirmation

It is my desire to have my own optometrist, Doctor _____name of optometrist_____, perform my postoperative follow-up care after my cataract/refractive (circle one) surgery. I have discussed this postoperative selection with my ophthalmologist, Doctor _____name of ophthalmologist_____.

Doctor _____name of ophthalmologist_____, has informed me that an optometrist may lawfully provide post-operative care under applicable state law. I understand that my optometrist will contact Doctor _____name of ophthalmologist_____ immediately if I experience any complications related to my eye surgery. I understand that I may also contact Doctor _____ name of ophthalmologist_____at any time after the surgery.

Patient: _____ Date: _____

Witness: _____ Date: _____

Optometrist Confirmation

I have agreed to provide follow-up care for _____patient's name_____ . I will see the patient after surgery when Doctor _____name of ophthalmologist_____notifies me that she/he is releasing the patient to my care. I agree to notify Doctor _____name of ophthalmologist_____ _____immediately should complications arise and to provide written progress reports during my portion of the postoperative period.

Optometrist: _____ Date: _____