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**Consent for planned comanagement after eye surgery**

**Patient Name:**

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of surgeon) will be performing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type of surgery)on me. Because of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (state reason), I would like Dr. \_\_\_\_\_\_\_\_\_\_ (name of comanaging optometrist) to perform my postoperative follow-up care. I have discussed this postoperative selection with my surgeon.

I understand that my comanaging optometrist Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of comanaging optometrist) will contact my surgeon immediately if I experience any complications related to my eye surgery.

**I understand that I may contact Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of surgeon) at any time after the surgery.**

Patient: Date: