This form is intended as a sample. It does not constitute the standard of care nor does it provide legal advice. It contains the information OMIC recommends the surgeon personally discuss with the patient.

**How to use this sample**

* Please modify it to fit your practice.
* **Delete this instruction box.**
* Add your letterhead to the first page of the consent form.
* Change font size if necessary.

**After the patient signs the form**

* Give the patient a copy of the signed form.
* Keep the original in the patient’s medical record.

**Version** 05/23/23

**[Your Letterhead]**

**Consent for Comanagement after LAL Cataract Surgery**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_**

**Patient Confirmation**

I understand that my ophthalmologist, Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_, will be performing eye surgery on me and optometrist, Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, will be co-managing my postoperative care. My surgeon has discussed this postoperative care selection with me and answered my questions.

I understand that the comanaging optometrist will contact my ophthalmologist immediately if I experience any complications related to my eye surgery.

I understand that I may contact my ophthalmologist at any time after the surgery.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature (or person authorized to sign for patient) Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name Relationship to patient**