1400 Dry Creek Drive
Longmont, CO 80503
303-772-3300

300 Exempla Circle #120
Lafayette, CO 80026
303-772-3300

Consent For Co-Management
After Eye Surgery

Please sign and return via FAX immediately to 303-774-8395

Eye Care Center of Northern Colorado will fill out this form and FAX it to you

Patient Name:

Date of Birth:

Patient Confirmation

Dr. ____________________________ will be performing cataract surgery on my Left/Right eye.

Due to travel, convenience or other circumstances, it is my desire to have my Primary Optometrist/Ophthalmologist, Dr. ______________________________, perform my postoperative follow-up care.

I have discussed this postoperative selection with my surgeon, Dr. ____________________________.

I understand that my Optometrist/Ophthalmologist will contact my surgeon immediately if I experience any complications related to my eye surgery. I understand that I may also contact my surgeon at any time after surgery if needed.

Patient Signature: ____________________________________ Date: ____________________________

Witness: ____ Date: ____________________________

Co-Managing Optometrist/Ophthalmologist Confirmation

I have agreed to provide follow-up care to the above-mentioned patient. I will see the patient after surgery when the surgeon, Dr. _____________________ notifies me that he is releasing the patient to my care.

I agree to notify the surgeon immediately should any complications arise and to provide written progress reports during my portion of the postoperative period.

Signature: ____ Date: ____________________________

Surgeon Confirmation

Signature: ____ Date: ____________________________

Surgeon Release Date

The patient is found to be stable and in appropriate postoperative condition with normal vital signs. The eye is stable and in appropriate condition. The patient may be followed by the primary eye care provider (co-managing doctor) for postoperative care, as to the above confirmations.

Surgeon Signature: ____________________________________ Date: ____________________________