eye CARE center of northern colorado, pc

CONSENT FOR CO-MANAGEMENT AFTER REFRACTIVE SURGERY

Patient Name: _____Date of Birth: _____

Patient Confirmation **Aimee Verner, M.D. will be performing LASIK/PRK/ICL on me on _____**

as well as the One Day post-op exam on: _____.

Due to travel, convenience or other circumstances, it is my desire to have my own optometrist/ophthalmologist, Dr. _____, perform my postoperative follow-up care.

I have discussed this postoperative selection with Dr. Verner who has informed me that an optometrist may lawfully provide postoperative care under applicable state law. I understand that my optometrist/ophthalmologist will contact Dr. Verner immediately if I experience any complications related to my eye surgery.

I understand that I may also contact Dr. Verner at any time after the surgery.

Patient Signature: _____Date:_____

Co-Managing Optometrist /Ophthalmologist/Confirmation

I have agreed to provide follow-up care for _____. I will see the patient after surgery when Dr. Verner notifies me that she is releasing the patient to my care. I agree to notify Dr. Verner immediately should complications arise and to provide written progress reports during my portion of the postoperative period.

Co-Managing Doctor Signature: _____Date: _____

Surgeon Confirmation

Surgeon Signature: _____Date: _____

Surgeon Release Dates

The patient is found to be stable and in appropriate postoperative condition with normal vital signs. The eyes are 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.

Planned Release Date: _____ Date: _____

☐ WEEK 1 POST-OP SCHEDULED ☐ MONTH 1 POST-OP SCHEDULED

IF POST-OP APPOINTMENTS ABOVE HAVE NOT YET BEEN SCHEDULED, PLEASE CONTACT THIS PATIENT TO GET THEM SCHEDULED. THANK YOU.