eye CARE center
of northern colorado, pc

1400 Dry Creek Drive—Longmont, CO 80503

303-772-3300

CONSENT FOR CO-MANAGEMENT AFTER CATARACT SURGERY

Patient Name: _____Date of Birth: _____

Patient Confirmation **Dr._____will be performing cataract surgery on**

my Right eye _____ and on my Left 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: _____

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 they are releasing the patient to my care.

I agree to notify the surgeon immediately should any complications arise and to provide written exam notes 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 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.

Planned Release Date **1st eye OD / OS**: _____ Date: _____

☐ WEEK 1 POST-OP SCHEDULED

Planned Release Date **2nd eye OD / OS**: _____ Date: _____

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

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