TRANSFER OF CARE

GULFCOAST EYE CARE

Patient (*Last Name*): (*First*): (*M.I.*):

Is currently a patient of Gulfcoast Eye Care and chooses to have his/her care transferred to their co-managing doctor.

Care for post operative management and eyeglass prescription (*as indicated*) will be transferred to:

Doctor Name:

Doctor Phone:

Effective (*Date*):

COMMENTS:

I freely choose to receive my post operative care with the above named doctor.
I will contact Gulfcoast Eye Care if I have any questions or if I need additional post-operative care.

Patient Signature: Date:

Surgeon Signature: Date: