

# TRANSFER OF 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:

PROVIDING **EXCELLENCE** IN EVERY ASPECT OF EYE CARE

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