CONSENT FOR COMANAGEMENT AFTER EYE SURGERY

GULFCOAST EYE CARE

Patient Name:

PATIENT CONFIRMATION

Dr. Manning will be performing (type of surgery) on me. Because of , it is my desire to have my own ophthalmologist/optometrist, Dr. , perform my postoperative follow-up care. I have discussed this postoperative selection with my surgeon, Dr. Manning.

I understand that my ophthalmologist/optometrist will contact Dr. Manning immediately if I experience any complications related to my eye surgery. I understand that I may also contact Dr. Manning at any time after the surgery.

Patient Signature (or Person Authorized to Sign for Patient) Date

OPHTHALMOLOGIST/OPTOMETRIST CONFIRMATION

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

Ophthalmologist/Optometrist Date