CONFIRMATION OF POST-OPERATIVE CO-MANAGEMENT SELECTION BY THE PATIENT

Patient Name: _____

Optometrist Confirmation

I have agreed to provide follow-up care for _____. I will see the patient after surgery if the patient desires, when Dr. Falkenberg/Dr. Hudson/Dr. Shen notifies me that the patient is released to my care. I agree to notify Dr. Falkenberg/Dr. Hudson/Dr. Shen immediately should complications arise and to provide written reports while the patient is under my care during the post-operative period.

Optometrist: _____ Date: _____

Patient Confirmation

It is my desire to have my own optometrist, Doctor_____, perform my postoperative follow-up care after my cataract surgery. I have discussed this post-operative selection with my ophthalmologist. Dr. Falkenberg/Dr. Hudson/Dr. Shen has informed me that an optometrist may lawfully provide post-operative care under applicable state law. I understand that my optometrist will contact Dr. Falkenberg/Dr. Hudson immediately if I experience any complications related to my eye surgery. I understand that I may also contact Dr. Falkenberg/Dr. Hudson/Dr. Shen at any time after the surgery.

Patient: _____Date:_____

Witness: _____Date:_____

REFUSAL OF CO-MANAGEMENT

I choose not to return to the optometrist that referred me for this cataract evaluation, but rather stay under the post-op care of Dr. Falkenberg/Dr. Hudson/Dr. Shen.

Patient:_____Date:_____

Witness: _____ Date:_____