Asheville eye Associates

Confirmation of Postoperative Comanagement
Selection by the Patient

Patient Name: _____ Medical Record #_____

Optometrist Confirmation

I have agreed to provide follow-up care for _____. I will see the patient after surgery when Dr. _____ (surgeon) notifies me that he is releasing the patient to my care. I agree to notify the surgeon if complications arise. Written progress reports will be provided consistently to the surgeon during the patient's postoperative period.

_____ _____
Optometrist Signature Date

Patient Confirmation

It is my decision to have my own optometrist, Doctor_____, perform my postoperative follow-up care after my surgical procedure. I have discussed this postoperative selection with _____(surgeon). _____Patient Initials

My surgeon has informed me that an optometrist may lawfully provide post-operative care under applicable state law. I understand that my optometrist will contact the surgeon immediately if I experience any complications related to my eye surgery. I understand that I may also contact the surgeon at any time following the surgery.

_____ _____ _____
Patient Signature Date Time

_____ _____
Witness Signature Date

_____ _____
Physician Signature Date