GRAND RAPIDS OPHTHALMOLOGY
Eye Care | Surgery | Laser Correction

CO-MANAGEMENT PATIENT CONSENT FORM

Patient Name: _____ Date of Birth: _____

Phone: _____

I understand that Dr._____ will be performing my Cataract Surgery and any immediate post-operative care until my condition is stable.

Once medically stable, it is my desire to have my primary optometrist/ophthalmologist, Dr._____ perform my post-operative care as outlined below.

☐ 1 day post operative appointments

☐ 1 week post operative appointments

☐ 1 month post operative refraction

I understand that a record of findings will be sent to my surgeon following each visit with my primary eye care provider and that my surgeon will be informed if I experience any complications related to my eye surgery. I understand that I may also contact my surgeon at any time after the surgery.

Patient Signature_____ Date _____

Witness _____Date _____