GRAND RAPIDS OPHTHALMOLOGY

Direct referral line 616.456.2020
Fax 616.365.1130

REQUEST FOR CATARACT CO-MANAGEMENT

Dr. _____ has referred me to Dr. _____ for evaluation and, if indicated, surgical management of cataracts.

I understand that Dr. _____would perform any surgery and provide immediate postoperative care until my condition is medically stable.

Once medically stable, I would prefer to continue my relationship with Dr._____.

I understand that Dr. _____ and Dr. _____ will remain in contact before, during, and after my surgical experience and I am free to contact my ophthalmologist or optometrist at any time. The benefits and risks of having co-managed postoperative care have been explained to me.

_____

Printed patient name

_____

Patient signature

_____ _____

Witness Date