GRAND RAPIDS OPHTHALMOLOGY

Eye Care | Surgery | Laser Correction

Request for Cataract Co-Management

See every moment.®

Dr. _____has referred me to Dr._____
Referring Doctor

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. _____
Referring Doctor

I understand that Dr. _____and Dr. _____
Referring Doctor

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

This form is also available online at www.seeitclear.com/referring-doctors GRO-2710 (2016)