



**CONSENT FOR CO-MANAGEMENT
AFTER EYE SURGERY**

Patient Name: _____

Patient Confirmation

Doctor Jani will be performing _____ on me. It is my desire to have my own optometrist, Doctor _____, perform my post-operative follow-up care. I will discuss this post-operative selection with my surgeon, Doctor Jani.

I understand that my optometrist will contact Doctor Jani immediately if I experience any complications related to my eye surgery. I understand that I may also contact Doctor Jani at any time after the surgery.

Patient: _____ Date: _____
signature

Witness: _____ Date: _____

Optometrist Confirmation

I have agreed to provide follow-up care for _____. I will see the patient after surgery when Doctor Jani notifies me that he is releasing the patient to my care. I agree to notify Doctor Jani immediately should any complications arise and to provide written progress reports while the patient is under my care during the post-operative period.

Optometrist: _____ Date: _____
signature