CONSENT FOR COMANAGEMENT
AFTER EYE SURGERY

Patient Name: _____
Printed Name

Patient Confirmation

Aaron J. Affleck, MD will be performing _____
Type of surgery

on me. It is my desire (voluntarily, knowingly and willingly) to have my own primary optometrist _____, perform my postoperative follow-up care because:
Name full of Optometrist

_____

I have discussed with my optometrist the following:

_____ I understand I will not start my postoperative follow-up care with my optometrist, until Dr. Affleck deems I am postoperatively stable.
Initial

_____ I understand I may contact Dr. Affleck at any time after my surgery at no extra cost.
Initial

_____ I understand that my optometrist, will contact Dr. Affleck immediately if I experience any complications related to my eye surgery. I will be referred back to Dr. Affleck if needed.
Initial

_____ I understand the risks, benefits and logistics of co-management, including the fee arrangement, and I wish to proceed.
Initial

_____ I understand that a record of findings will be sent to Dr. Affleck following each visit with my optometrist regarding the postoperative follow-up care.
Initial

_____ I understand a copy of this form will be faxed to Dr. Affleck.
Initial

Patient:_____ Date: _____
Signature

_____ Date: _____
Optometrist's Signature

_____
Optometrist's Address