Marc R. Sanders, M.D., F.A.C.S.
Board Certified Ophthalmologist

Andrew K. Salem, M.D.
Ophthalmologist, Cornea Specialist

DIAGNOSTIC
EYE CENTER

Aric R. Welton, O.D.
Therapeutic Optometrist

Stephanie M. Lozano, O.D.
Therapeutic Optometrist

Consent for Co-Management After Eye Surgery

Patient Name: _____ **DOB:** _____

Patient Confirmation

I understand that Diagnostic Eye Center will be performing surgery on me and that my optometrist will be co-managing for the reason initialed by me below:

Patient Initial (Please select one)

_____ Clinically appropriate and in the patient's best interest

_____ Other: _____

It is my desire to have my optometrist, Doctor _____, perform my postoperative care. I will discuss this postoperative selection with my surgeon.

I understand that an optometrist may lawfully provide postoperative care under applicable state and federal law. I understand that my optometrist will contact Diagnostic Eye Center immediately if I experience any complications related to my eye surgery. I understand that I may also contact Diagnostic Eye Center at any time after my surgery.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Optometrist Confirmation

I have agreed to provide follow-up care for the patient listed above. I will see the patient after surgery when Diagnostic Eye Center notifies me that they are releasing the patient to my care. I agree to notify Diagnostic Eye Center immediately should any complications arise and to provide written progress reports during my portion of the postoperative period.

Optometrist Signature: _____ Date: _____