Sample Form

[Enter Clinic Name]

Election of Postoperative Care Form

Name:	**Chart #:**
Surgeon's Name :	
Planned Procedure & Eye:	**Date:**
Planned Procedure & Eye:	**Date:**

You have been given the information sheet and postoperative instructions for the care of your eye following surgery. It will also be necessary for you to have postoperative examinations following your surgery. **[Enter clinic name]** will be glad to perform those examinations for you. If, however, for reasons of traveling distance or other personal preference, you choose to have those follow-up examinations performed by another eye care professional, please advise us at this time so that we may file the insurance claim to Medicare appropriately. Medicare will pay your local eye care professional directly for the services he/she performs. Your transfer of care will occur only if and when it is medically appropriate. It will be the responsibility of your local eye care professional to provide us with information on your postoperative status. If, for any reason, you should experience any complications, or if you would like to return to our care for any reason, you may and should do so.

Election of Postoperative Care Provider

[ ] *INITIAL*

I elect to have my local eye care professional examine me postoperatively, and I authorize [Enter clinic name] to release copies of my treatment sheets to the following doctor during my 90 day postoperative period.

Name of Provider Selected by Patient: ______________________________

[ ] *INITIAL*

I elect to return to [Enter clinic name] for my postoperative care.

I have read and understand this consent and authorization of release.

Patient's Signature: ______________________________

If patient is unable to sign, complete the following:

Relative or Legal Guardian Signature: ______________________________ Relationship: ______________

Witness' Signature: ______________________________ Date: ______________

Notice of Transfer of Care

Clinic Postoperative Care: From: ______________________ To: ______________________

Diagnosis: ______________________________

☐ Conventional IOL ☐ Presbyopia Correcting IOL ______________________________

Date of Transfer of Care: ______________________________

First appointment scheduled with co-manager on: ______________________________

WHITE COPY - Chart YELLOW COPY - Patient PINK COPY - Co-Manager