

Request for Clear Lens Exchange Co-Management

Dr. _____ has referred me to Dr. _____ of Shoreline Vision for evaluation and, if indicated, surgery.

I understand that Dr. _____ would perform any surgery and provide immediate post-operative care until my condition is medically stable. Once medically stable, I would prefer to continue my relationship with Dr. _____ for routine eye care, including a portion of my post-operative care.

I understand that Dr. _____ and Dr. _____ will remain in contact before, during and after my surgical experience.

I understand that I am free to contact either Dr. _____ or Dr. _____ at any time for any questions or concerns I have.

Patient's Printed Name

Date

Patient's DOB

Patient's Signature

Date

Witness

Date