Shoreline Vision
Vision Care. For Life.™

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