Cataract Surgery Co-Management
Patient Consent / Transfer of Care

Transfer of Care - Completed by Surgeon

Patient Last Name:_______________________________ Patient First Name:________________________________

Patient Date of Birth:_____/_____/_____ Date of Surgery:_____/_____/_____ Eye: RIGHT LEFT

Surgeon Name:________________ CPT for Surgery:____________ ICD-10 Used By Surgeon: _______________

Date that the surgeon released patient's post-operative care to co-managing optometrist:_____/_____/_____

Date that Vista Eye Care's co-managing optometrist assumes patient care:_____/_____/_____

Patient Consent - Completed by Patient and Surgeon

Dr._________________________________ is the surgeon that will be performing cataract surgery on me. It is my desire to have Dr. ____________________________ perform my post-operative follow-up care. I have discussed this post-operative care selection with my surgeon.

I understand that my optometrist will contact my surgeon immediately if I experience any complications related to my surgery. I understand that I may also contact my surgeon at any time after my surgery.

Patient's Signature:_________________________________ Date:_____/_____/_____

Surgeon's Signature:_________________________________ Date:_____/_____/_____

Confirmation of Care Transfer - Completed by Vista Eye Care Optometrist

I have agreed to provide follow-up care for ____. I will see the patient after surgery when the surgeon notifies me that they are releasing the patient to my care. I agree to notify th surgeon immediately, should complications arise, and to provide written progress reports during my portion of the post-operative period.

Optometrist's Signature:_________________________________ Date:_____/_____/_____