Williamson Eye Center

Postoperative Care Request Form

I _____ voluntarily, knowingly and willingly desire to have _____, my optometrist, perform follow-up care after my **CATARACT, YAG, SLT, LPI, PRK, LASIK** surgery. I wish to be followed by my optometrist because: (Check all that apply)

___ I live in _____ and am unable to travel to the surgeon's office.
___ I have chosen to return to my optometrist for a portion of my postoperative care.
___ I choose **not** to have my optometrist perform a portion of the postoperative care after surgery.

I understand that I will not see Dr. _____ (Optometrist) until the surgeon believes it is clinically appropriate. I have discussed my choice with Dr. _____ (Surgeon) and have been advised that he/she is competent to perform the necessary follow-up services for me. I have been assured that the surgeon will be contacted immediately if I experience any complication related to my surgery and I will be referred back to the surgeon if it becomes necessary.

I have been informed that I may receive additional statements and explanations of benefits from my insurance, because two physicians are providing care. I further understand that after a surgical procedure is performed there may be costs for glasses, frames, or contacts which are not included in this post operative care. The risks, benefits, and logistics of this arrangement have been explained to me and I desire to proceed.
I agree to the fee of $_____ per eye for my post op care with Dr. _____. I understand this is payable at my first post op visit.

_____ _____
Patient's Signature Date

I have agreed to provide postoperative care for _____ following surgery. I look forward to assuming his/her care when you believe it is clinically appropriate. I will keep you advised of his/her progress and will contact you if the patient has complications which warrant your attention.

_____ _____
Optometrist's Signature Date

I acknowledge receipt of this fully completed and signed form.

_____ _____
Surgeon's Signature Date

(WEC office use only)

Patient Name: _____ Date of Birth: _____

Date of surgery: _____ Procedure: _____ Diagnosis: _____ Eye: OD / OS 1st / 2nd Clinic postoperative care from: _____ to: _____

Beginning date for your office to bill post op period: _____

Notice of transfer of care to: _____, OD

First appointment scheduled with co-managing Doctor: _____

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