

**CONSENT FOR CO-MANAGEMENT
AFTER EYE SURGERY**

Patient Name: _____

Type of Surgery: _____

Patient Confirmation

Dr. Amjad Khokhar will be performing ophthalmologic surgery on me. Because of _____, it is my desire to have my own ophthalmologist/optometrist, Dr. _____ perform my postoperative follow-up care. I have discussed this postoperative selection with my surgeon, Dr. Amjad Khokhar.

Dr. Amjad Khokhar has informed me that an optometrist may lawfully provide postoperative care under applicable state law. I understand that my ophthalmologist/optometrist will contact Dr. Amjad Khokhar immediately if I experience any complications related to my eye surgery. I understand that I may also contact Dr. Amjad Khokhar at any time after the surgery.

Patient: _____ Date: _____

Witness: _____ Date: _____

Ophthalmologist/Optometrist Confirmation

I have agreed to provide follow-up care for (patient's name): _____. I will see the patient after surgery when Dr. Khokhar notifies me that she/he is releasing the patient to my care. I agree to notify Dr. Khokhar immediately should complications arise and to provide written progress reports during my portion of the postoperative period.

Ophthalmologist/Optometrist: _____ Date: _____