Consent for OD Cataract Co-Management

NIELSEN EYE CENTER
CENTER FOR SIGHT

Date: _____ Fax #:_____

Dear Dr. _____, Patient Name: _____

Date of Birth: _____

I had the opportunity of seeing the above captioned patient for evaluation of gradual, progressive blurred vision, which is now interfering with the ability to see clearly.
A full evaluation was done including slit lamp examination and dilated fundus examination. Cataracts were found to be the cause of the loss of vision.

Impression: Visually significant cataracts, interfering with visual functioning.
I have discussed the risks, benefits, and alternative forms of treatment for cataract surgery, and the patient has seen a video on cataract and implant surgery. The patient expresses understanding of the surgery and the patient's questions have been answered. The patient would like to return to your excellent care postoperatively, once the eye is stabilized. This will benefit the patient from both from a geographical convenience, optical convenience, and for continuity of care. I will fax you a note postoperatively once the patient is stabilized prior to transferring them back to your care.

Cataract surgery has been scheduled on _____ for the _____ **eye** and _____ for the

_____ **eye.** Surgery is subject to change.

The patient is scheduled for a post-operative follow-up on _____ at _____ in your office or they will call to set up an appointment.

_____ ***Patient declined***

I understand that my optometrist will be co-managing in my post-operative care, but I can return to my surgeon if I have any issues or concerns. **Steven Nielsen MD / Helen Moreira MD**

Patient Signature:_____Date:_____

I agree to co-manage this patient and to notify the surgeon should any complications arise and to provide written progress reports during the post-operative period. Directions: *Please sign and fax this form back to The Nielsen Eye Center (Fax)* ***617-665-6704.***

Co-Management Payment should be made to _____

and mail to _____

Optometrist Signature:_____Date:_____

Thank you kindly for your confidence and your continued referrals.
Dr. Nielsen, MD, Dr. Moreira, MD

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NIELSEN EYE CENTER
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Date:_____ Fax #:_____

Dear Dr. _____,

Patient Name: _____D/O/B:_____

Your patient underwent cataract surgery on the **right eye** on _____.

A single focus/multi focus lens was implanted into the eye. The lens parameters were:

The patient has chosen one of the following set of drops and is now being utilized.

Ketorolac/Diclofenac- 1 drop 2x a day for 3 weeks after surgery in operative eye.

If the patient had laser cataract surgery they will also be using:

Ocuflox- 1 drop 4x a day for 1 week after surgery in operative eye.

These drops should be continued until they are gone.

I am returning the patient to your excellent care for further postoperative evaluation and optical correction.

Included is a patient post-operative form. Please fill out the appropriate patient form after each post-operative visit and fax forms to the Nielsen Eye Center at 617-665-6704.

If there are problems that need my attention, please do not hesitate to call or refer back to me at any time.

I appreciate the confidence you show in my ability to help your patients.

Sincerely,
Steven A. Nielsen, M.D.
Helen Moreira M.D.

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