FICHTE, ENDL & ELMER EYECARE ELECTION OF POSTOPERATIVE CARE

Name _____ ID# _____

Surgeon's Name _____

Planned Procedure & Eye(circle) LASIK Cataract Other _____ OD OS OU

You have been given the information sheet and postoperative instructions for the care of your eye(s) following surgery. It will also be necessary for you to have postoperative examinations following your surgery. Fichte, Endl & Elmer Eyecare will be glad to perform those examinations for you. If, however, for reasons of traveling distance or other personal preference, you choose to have those follow-up examinations performed by another eye-care professional, please advise us at this time. Your transfer of care will occur only if and when it is medically appropriate. It will be the responsibility of your local eye-care professional to provide us with information on your postoperative status. If, for any reason, you should experience any complications, or if you would like to return to our care for any reason, you may and should do so.

ELECTION OF POSTOPERATIVE CARE PROVIDER

Initial:

☐ I elect to have my local eye-care professional examine me postoperatively and I authorize Fichte, Endl & Elmer Eyecare to release copies of my treatment sheets to the following doctor during my postoperative period.

_____

Name & Address of Provider Selected by Patient

☐ I elect to return to Fichte, Endl & Elmer Eyecare for my postoperative care.

I HAVE READ AND UNDERSTAND THIS CONSENT AND AUTHORIZATION OF RELEASE.

Patient's signature _____

If patient is unable to sign, complete the following:
Relative or legal guardian's signature _____ Relationship _____

Witness' signature _____ Date _____

NOTICE OF TRANSFER OF CARE (TO BE COMPLETED BY FICHTE, ENDL & ELMER EYECARE)

FEEE postoperative care: From _____ To _____

Diagnosis: _____

Date of transfer of care _____

First appointment scheduled with co-manager on _____