DAVID D. RICHARDSON, MD, INC.
DAVID RICHARDSON, M.D. • SAN MARINO EYE

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Consent For Care Partnership After Eye Surgery

PATIENT'S NAME: ____

PATIENT CONFIRMATION

Dr. David Richardson, MD will be performing _______________________ on me. It is my desire to have my own ophthalmologist Doctor ______________________ perform my postoperative follow-up care. I have discussed this postoperative selection with my surgeon, Doctor Richardson. I understand that my ophthalmologist will contact Doctor Richardson immediately if I experience any complications related to my eye surgery. I understand that I may also contact Doctor Richardson at any time after the surgery.

____ ____________________

Signature Date

____ ____________________

Witness Date

OPHTHALMOLOGIST

I have agreed to provide follow-up care for ________________________. I will see the patient after surgery when Doctor Richardson notifies me that he is releasing the patient to my care. I agree to notify Doctor Richardson immediately should complications arise and to provide written progress reports during my portion of the postoperative period.

____ ____________________

Ophthalmologist Date