Co-Management Consent

Dear Dr. Wolin,

I would like my optometrist to provide some of my follow-up care if I decide to have surgery. I have discussed this with my optometrist and have been advised of their training, licensure and competence to provide these necessary aftercare services for me. I understand that this is called "co-management" and there is no direct financial relationship between you and my optometrist. It has been explained to me that my insurance company will reduce payment to you in order to reimburse my referring optometrist for the postoperative care rendered following surgery. I have also been assured that you will be contacted immediately if I experience any complication related to my surgery, that I can contact you directly at any time, and that I will be immediately referred back to you if it becomes necessary. I further authorize you and my optometrist to share with one another any information that you deem relevant to providing me with appropriate care either before or after surgery.

☒ _____ _____

Patient Signature Date

Dear Dr. Wolin,

I am referring the above-named patient of mine for cataract and/or PCO evaluation. If surgery is performed, I have agreed to provide whatever necessary postoperative care. Please call or ask the patient to call my office for an appointment at his/her convenience within the first 3 days following your final postoperative examination. I will keep you advised of this patient's progress during the global period and will contact you immediately if the patient has complications with warrant your attention.

☒ _____ _____

Referring Doctor's Signature Date

Please **SIGN** & **FAX** this document to **(847) 255-8727**

NORTHWEST OPHTHALMOLOGY

LAWRENCE D. WOLIN, M.D.
1602 W. Central Road • Arlington Heights, IL 60005
Phone: (847) 255-3515

Referral Request

Patient Contact Information

Patient Name _____ Referral Date _____

Patient Phone Number(s) _____ Insurance Company Name _____

I am referring this patient to you for consultation for: **OU / OD / OS** (circle one)

- ☐ Cataract evaluation
- ☐ Glaucoma
- ☐ LASIK consultation
- ☐ YAG capsulotomy
- ☐ Diabetic retinopathy
- ☐ Other: _____

Pertinent History

☐ Painless, progressive vision loss to the point of interfering with activities of daily living and enjoyment and/or: _____

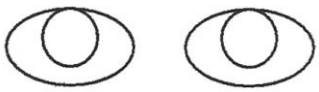
_____

_____

VA	SC	CC	PH
OD			
OS			

MRx	SPH	CYL	AXIS
OD			
OS			

T_a



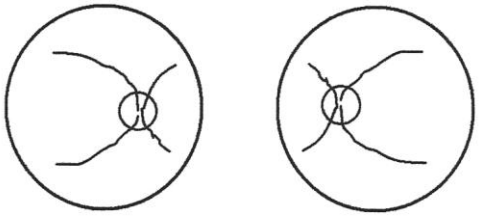
Pertinent Exam Findings and Concerns

_____

_____

_____

_____



☒ _____ _____

Referring Doctor's Signature Date

Please **FAX** this document to **(847) 255-8727**

Thank you for your referral!

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