



Post-Operative Surgery Instructions & Consent Agreement

Patient Name <pname>

Surgery Date <date>

- Leave the plastic shield in place for the remainder of the day and through the night.
• Wear the shields at night for the next five nights.
• Do not touch or rub the eye.
• To reduce discomfort, keep both eyes closed as much as possible the day of surgery.
• Take precautions not to get your eye wet when you shower or bathe.
• Take any other medications exactly as prescribed by your doctor.

Your vision may fluctuate for the first few days. This will usually stabilize after the first week. Your eye may continue to tear, have a "foreign body" sensation, or be sensitive to light. Taking all of your medications as directed will help relieve any discomfort. Protect your eyes from sun radiation with a good pair of sunglasses that provide UV protection. Heavy UV exposure can burn your eyes and cause regression problems any time during the first year.

Though an eye infection is very rare, during the first week be careful not to get anything in your eye (including soap and water) and do not use eye make-up or mascara. Normal activities may be resumed after the first week, except for swimming (your doctor will advise you when it is safe to resume swimming).

Medications: (starting 4 hours after surgery or after you wake up from sleeping)

- During the first 24 hours place one drop of TOBRADEX in the operated eye(s) every 2 hours while you are awake. Then place one drop of TOBRADEX in the operated eye(s) 4 times a day for 4 days.
• THERATEARS (preservative free over the counter artificial tears)
During the first 2 months place one drop of artificial tears in the operated eye(s) every 2 hours while you are awake. Then place one drop of artificial tears in the operated eye(s) 4 times a day for 6 additional months.

Drops must be used 5 minutes apart to prevent one from washing out the other.

Post Operative Care: Your first post-op visit is scheduled with <refod>.

Date:

Place:

Time:

I understand and consent to the fact that <refod>, a licensed doctor of optometry will provide my postoperative care following my eye surgery, for the following reason: continuity of care/travel/patient preference/other (specify) _____. The possible benefits or risks of this arrangement and each doctor's qualifications have been discussed with me. I understand my payment obligations to Dr. Cathleen McCabe and <refod> and all of the other information that has been presented to me about my postoperative care, and voluntarily consent to this co-management arrangement. I further authorize Dr. Cathleen McCabe, <refod>, and other health care personnel involved in performing this procedure and providing care, to share with one another information relating to my health, my vision, or this procedure that they deem relevant to providing me with appropriate care.

<pname>
Patient Name (print)

Patient Signature Date

Witness Signature Date

Surgeon Signature