



## Community Optometrist Cataract Aftercare Co-Management Agreement

(place "X" in check boxes)

I acknowledge that I have read the following documents and understand my co-management obligations:

1. Essential Co-Management Information for Referring Optometrists
2. Essential Cataract Surgery Information for Co-Managing Optometrists
3. Medicare Billing and Cataract Co-Management by Optometrists

(Download these documents from <http://www.baysidehealth.org.au/Ophthalmology/>)

I agree to providing cataract aftercare for patients I have referred to the Alfred Hospital Ophthalmology Clinic following these guidelines.

I agree to providing cataract aftercare to patients who reside or work near my practice who have been referred for cataract surgery by their general practitioners or internally referred within the Alfred Hospital.

Signature.....

Date ...../...../.....

Dr / Mrs / Ms / Mr Surname..... First Name.....

Practice Name.....

Practice Street Address..... P'Code.....

Practice Postal Address (if different) ..... P'Code.....

Provider No. ....Practice Ph ( )..... Practice Fax( ).....

e-mail (please print in block capitals for clarity).....

*Privacy Statement: These details will not be disclosed to any third parties with the exception of patients being co-managed.*

**Fax this form to 9076 2709 (all hrs)**

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EXCELLENCE IN SERVICE AND CARE  
The Alfred Hospital is a member of Bayside Health

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