

**CO-MANAGEMENT TRANSFER OF CARE FORM**

Please SIGN and fax back to the Surgery Center. Retain in patient file.

C. Dan Siapco, MD  
Carlindo Pereira, MD

Eye Associates Surgery Center  
2100 Little Mountain Lane  
Mount Vernon, WA 98274

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Hm. Ph: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Other insurance: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_  OD  OS

Procedure/Lens: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_ CPT Code: \_\_\_\_\_

Facility:  Eye Associates Surgery Center  United General Hospital

Co-Managing Optometrist or Ophthalmologist: \_\_\_\_\_

Date Post-Op Care Began: \_\_\_\_\_ Date Post-Op Care ended: \_\_\_\_\_

Post-Op Uncorrected VA: OD 20/\_\_\_\_ OS 20/\_\_\_\_

Post-Op Exam Findings: \_\_\_\_\_

Medications: \_\_\_\_\_

Post-Op visits to schedule for this patient:

\_\_\_\_\_  30 Day  90 Day  6 Mo.  1 Yr.

Surgeon Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I accept the Transfer of Care for the above mentioned patient:**

**PECP SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**FAX SIGNED FORM TO: 360-424-6954 or 360-416-8280**