ADVANCED VISION SURGERY

Patient:
DOB: Age:
Patient#: AC#:
Physician:
DOS: Sex:

Informed Consent

PATIENT INFO.

Last Name	First Name	Middle Name	DOB

Age	Gender	Performing	Anesthesiologist

Procedure Description	Pre Op Diagnosis	Allergies	Patient Medication

Surgeon	Pre Op Diagnosis

I hereby authorize my surgeon to perform the following procedure:

Patient:
DOB: Age:
Patient#: AC#:
Physician:
DOS: Sex:

Informed Consent

Additional Procedures: My healthcare provider may find a new or different condition, or a new conditionor problem might arise during the procedure. If he/she feels that other procedures are needed, I agree to these procedures. I understand that no guarantee can be made about the outcome of this procedure.

Anesthesia and Pain Control: My healthcare provider has told me about the medicines that will be used to managemy pain or make me sleepy for this procedure. He/ She has told me about the risks, benefits, and complications of anesthesia and pain control medicines.Sometimes an additional injection of medication is given by the surgeon around or behind the eye to help with pain control.Additional risks with this injection include bleeding around the eye, damage to the eye, damage to the optic nerve or inadvertent introduction of medication into the spinal fluid.

How the procedure may help me: My healthcare provider has explained the benefits of the procedure and Iunderstand them.

How the procedure may harm me: I understand the risks of this procedure or treatment include: RETINAL DETACHMENT, HEMORRHAGE IN EYE, INFECTION IN EYE, CATARACT, GLAUCOMA, LOSS OF VISION, LOSS OF EYE, NEED FOR MORE SURGERY, SCAR TISSUE FORMATION IN THE EYE, INFLAMMATION IN EYE, SWELLING OF OCULAR TISSUES, DROOPY EYELID, LATE INFECTION, CHRONIC PAIN, DOUBLE VISION, AND INCREASED NEARSIGHTEDNESS.

Some common risks include: Pain, infection, bleeding (which may require a transfusion), nerve injury (I might havenumbness or lose strength or function of a body part), blood clots, injury to nearby structures, including perforation (poking a hole in some part of my body that was not intended), and reaction to a medication. The risks of the procedure can be serious, and there is a possibility of death.

Other choices if I don’t have this procedure: I have been told of other reasonable treatment choices. I know there risks and possible benefits of these other choices. I have also been told of the risks and possible benefits of having no procedure or treatment for this condition.

Other people may be present: Some parts of the procedure may be completed by other members of the healthcareteam. Team members may change during the procedure. Observers and other participants may be present for medical education or support.

Disposal of Tissue, Organs, or Body Parts: If any tissue, organs, or body parts are removed, after necessary testing,they will be disposed of with respect.

Photography and Video Recording: My procedure may be recorded at the request of my physician.

I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. By my signature I herby consent to the performance of this procedure. I understand that no guarantee or assurance has been made to the results of the procedure and that it may not cure the conditions. My physician has also discussed with me the probability of success of this procedure as well the probability of serious side effects.