

Allatoona Eye Institute, PC
Cartersville, GA 30120
(770) 382-3598

Physician's Surgical Procedure Disclosure and Patients Consent

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure so that you may make the decision whether or not to undergo the procedures after knowing the risks involved and any treatment alternatives available to you. This information is not meant to alarm you; it is an effort to make you better informed so that you may give or withhold your consent to the procedure. If you do not understand any of the information provided, ask your physician to explain it.

1. DIAGNOSIS: I (we) voluntarily request my physician, Jeffrey R. Brant, MD, and/or Feng Zhao, MD, PhD, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my CONDITION:

CLOUDING OF LENS OF EYE (CATARACT)

2. PROCEDURE(S): I (we) understand that the following surgical procedure or procedures are planned for me on or about _____. I voluntarily consent to and authorize this (these) PROCEDURE(S) for the following purpose(s):

REMOVAL OF CLOUDY LENS (CATARACT) FROM RIGHT EYE USING AN ULTRASONIC (VIBRATING) PROBE WITH SUCTION; PLACEMENT OF NEW PLASTIC, PERMANENT INTRA-OCULAR LENS;
(PHACOEMULSIFICATION OF RIGHT CATARACT WITH IOL)

3. MATERIAL RISKS: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks related to the performance of the surgical, medical and/or diagnostic procedure planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins or lungs, hemorrhage, allergic reactions and even death. I (we) also realize that the following additional RISKS may occur in connection with this (these) procedure(s):

- RETINAL DETACHMENT AND DISLOCATION OF LENS
- DEVELOPMENT OF GLAUCOMA (INCREASED PRESSURE IN EYE)
- BLEEDING AND/OR INFECTION INSIDE OR OUTSIDE OF EYE
- RED OR PAINFUL EYE
- PTOSIS (DROOPY EYELID)
- IRREGULAR PUPIL
- SECONDARY CATARACT
- LOSS OF DEPTH PERCEPTION, BLURRING OF VISION, DOUBLE VISION, OR BLINDNESS
- LOSS OF EYE
- SWELLING OF LAYER UNDER THE RETINA (CHOROIDDAL EFFUSION)
- CHANGE IN FOCUS, REQUIRING NEW SPECTACLE LENSES (REFRACTIVE CHANGES)
- WRINKLING OF RETINA (MACULAR PUCKER)
- SWELLING OF THE CENTER OF RETINA (CYSTOID MACULAR EDEMA)
- LOSS OF NIGHT VISION, PERIPHERAL VISION, DISTORTION OF VISION OR BLIND SPOTS
- SWELLING OF THE CORNEA (CORNEAL EDEMA) AND NEED FOR TRANSPLANT TO CORRECT
- LESS ATTRACTIVE APPEARANCE, E.G., DROOPY EYELID

COMPLICATIONS OF LENS IMPLANTATION MAY DEVELOP DURING SURGERY, DAYS, WEEKS, MONTHS OR EVEN YEARS LATER. THEY INCLUDE:

- LOSS OF CORNEAL CLARITY
- INFECTION
- UVEITIS (INFLAMMATION OF THE TISSUES OF THE EYE)
- IRIS ATROPY (THE COLORED PART OF THE EYE DEGENERATING AND WASTING AWAY)
- GLAUCOMA
- BLEEDING IN THE EYE
- INABILITY TO ENLARGE PUPIL

4. ALTERNATIVES TO PROCEDURE: The following feasible alternatives to this procedure have been discussed with me:

OBSERVATION, CATARACT EXTRACTION WITHOUT LENS IMPLANTATION

5. PROGNOSIS IF NO TREATMENT: I have been informed of the prognosis if no treatment is provided, as follows:

A person who has a cataract and does not have surgery for it will likely have slowly or rapidly progressing further decrease in vision. Cataracts that become very advanced are often more difficult to remove surgically. If a person has cataract surgery without lens implantation they will need to wear a contact lens or thick spectacles to be able to see well.

6. ANESTHESIA: I (we) understand that anesthesia involves additional risks but I (we) request the use of an anesthetic for the relief and protection from pain during the planned and additional procedure(s), if any. I (we) realize the anesthesia may have to be changed without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic, including respiratory problems, drug reaction, paralysis, brain damage, or even death. Other risks and hazards which may result for the use of general anesthetics range from minor discomfort or injury to the vocal cords, teeth or eyes. I (we) understand other risks and hazards resulting from spinal or epidural anesthetics include headaches and chronic pain.

Additional anesthesia information supplied to the patient:

Anesthesia is to be administered by or under the direction of an Anesthesiologist
OR

Anesthesia is to be administered by _____

7. TREATMENT LIMITATIONS: I impose no specific limitations or prohibitions regarding treatment other than those that follow:
[If none, so state.]

8. DISPOSAL OF TISSUE: I (we) authorize the disposal of any surgically removed tissue or parts resulting from the procedure according to accustomed practice.

9. BLOOD PRODUCTS:

- I (we), consent to the use/administration/transfusion of blood products as deemed necessary.
- I (we), do not consent to the use/administration/transfusion of blood products as deemed necessary.

10. CONSENT TO TREATMENT OF UNFORESEEN CONDITIONS: I (we) understand that my physician may encounter or discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and associated technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

11. OUTCOME: I (we) understand that the practice of medicine is not an exact science, and that no warranty or guarantee has been made to me as to result or cure.

12. CONSENT TO TRAINING PARTICIPATION: This facility may have an educational role in the training of paramedical personnel.

Admittance of students and/or technical representatives

I (we) consent to the admittance of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

I (we) do not consent to the admittance of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

Participation of students and/or technical representatives

I (we) consent to the participation of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

I (we) do not consent to the participation of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

CONSENT:

I (we) have been given sufficient opportunity to ask questions about my condition, alternative treatments, risks of treatment, the procedures to be used, and the risks and hazards involved. All of my questions have been answered to my satisfaction, and I (we) have sufficient information to give this informed consent. I hereby consent to the above-described procedure.

I (we) certify that this form has been fully explained to me (us), and that I have read it, or have had it read to me (us), that the blank spaces have been filled in and that I (we) understand its contents.

Patient or Legally Responsible Person

Date: _____
Time: _____ (A.M./P.M.)

Signature of Witness (Include Position / Title)

Printed Name of Witness

To Be Completed By Physician After Patient Consent Completed:

I certify that the procedure(s) described above, including the risks, possible complications, anticipated results, alternative treatment options, including non-treatment, have been explained by me to the patient or his or her legal representative before the patient or his/her legal representative consented.

Treating Physician

Date: _____
Time: _____ (A.M./P.M.)