



Patient Name Surname : **BARCODE**  
File Number :  
Education :  
Job :  
State of mind : .....

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. \_\_\_\_\_ and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Date : .../.../.....

Hour : .....:.....

**PATIENT:**

Name-Surname : .....

Signature :

**Patient's Parent/ Legal Guardian (mother and father)/ Translator**

Name-Surname : .....

Name-Surname : .....

Signature :

Signature :

**DOCTOR- Ophthalmologist:**

Name-Surname : .....

stamp

Signature :