



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

GENERAL INFORMATION

This information is given to you to help you make an informed decision about having cataract and/or lens implant surgery. Once you have read this **Informed Consent**, you are encouraged to ask any questions you may still have about the procedure. It is impossible to list all of the possible risks and complications associated with surgery. Risks and complications that are considered to be unforeseeable, remote, or commonly known may not be specifically discussed in this consent.

Angiography is a diagnostic procedure in which a rapid sequence of photographs is taken to document the blood circulation of the retina/choroid. The dye is usually injected into a vein in the arm, forearm, or hand.

Since the fluorescein dye is a very bright yellow, the skin may appear jaundiced (yellowish) for a few hours and then the yellow color disappears. The dye is excreted through the kidney causing the urine to be bright yellow for 24-36 hours.

Documented adverse reactions to the dyes which can occur include: fatigue, nausea, vomiting, headache, upset stomach, light-headedness, fainting, hives, and itching.

Rarely, severe allergic reactions (anaphylaxis) or bronchospasm (which causes breathing difficulties) can occur and be life threatening.

The leakage of the fluorescein dye out of the blood vessel at the sight of injection can occur and can be painful; every effort is made to prevent this from occurring.

PATIENT'S STATEMENT OF ACCEPTANCE AND UNDERSTANDING

I hereby authorize and direct _____ and/or their designees to perform an angiogram and to provide such additional services as they may deem necessary and reasonable. This consent will be valid until I revoke it or my condition changes to the point that the risks and benefits of this procedure for me are significantly different.

I have informed my physician of any allergies to foods, iodine, or medications. I have informed my physician if I have asthma. I have informed my physician if I have had previous adverse experiences with ophthalmic dyes.

Intravenous fluorescein is usually not administered to pregnant or nursing women, although there is no scientific evidence to suggest that it might harm the fetus or nursing babies. I am not pregnant or nursing a baby.

I consent to the use of the above photographs and other materials for scientific purposes, provided my identity is not revealed by the pictures or the descriptive text accompanying them.

I have read this consent form. I understand this consent form. My questions, if any, have been answered to my satisfaction.

PATIENT'S ACCEPTANCE OF RISKS

Patient consent

I acknowledge that the doctor has explained;

- My medical condition and the proposed procedure, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.

- The anaesthetic required for this procedure. I understand the risks, including the risks that are specific to me.
- Other relevant procedure/treatment options and their associated risks.
- My prognosis and the risks of not having the procedure.
- There is no guarantee has been made that the procedure will improve my condition even though it has been carried out with due professional care.
- The procedure may include a blood transfusion.
- Tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital.
- If immediate life-threatening events happen during the procedure, they will be treated based on my discussions with the doctor or my Acute Resuscitation Plan.
- A doctor other than the Consultant may conduct the procedure. I understand this could be a doctor undergoing further training.

DOCTOR NOTE:

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I have reviewed all **three (3)** pages of this Informed Consent. The cataract and/or lens implant surgery has been explained to me in terms that I understand. I have been informed about the possible benefits, risks, and contraindications associated with the surgery. I understand that it is impossible for my doctor to inform me of every conceivable complication that may occur, and that there may be unforeseen risks. I have been given the opportunity to ask questions and have received satisfactory answers to my questions. I understand that no guarantee of a particular outcome has been given, and that my vision could become better or worse following surgery.

- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time, including after I have signed this form but, preferably following a discussion with my doctor.
- I understand that image/s or video footage may be recorded as part of and during my procedure and that these image/s or video/s will assist the doctor to provide appropriate treatment.
- If my ophthalmologist has informed me that if I have a high degree of hyperopic (farsightedness) and/or that the axial length of my eye is short, I am at increases risk for a rare complication known as nanophthalmic choroidal effusion. This complication could result in difficulties completing the surgery and implanting a lens, or other problems.
- If my ophthalmologist has informed me that if I have a high degree of myopia (nearsightedness) and/or that the axial length of my eye is long, I am at increased risk for a retinal detachment, whether or not I have surgery. Retinal detachments can lead to vision loss or blindness. Recent studies indicate that risk doesn't increased by the surgery, although an older study using different techniques did find an increased risk.
- I authorize the physicians and other health care personnel involved in performing my cataract surgery and pre- and post-operative care to share with one another any information relating to my health, my vision, or my surgery that they deem relevant to providing me with care. I give my permission for Dr. to use my photograph for display or promotion.

DOCTOR NOTE:

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I understand that it is impossible for the doctor who inform me of every possible complication that may occur. By signing below, I agree that my doctor has answered all of my questions, that I have been offered a copy of this consent form, and that I understand and accept the risks, benefits, and alternatives of _____ surgery.

I wish to have a _____ operation on my _____ Right eye _____ Left eye

PATIENT'S NOTE:.....

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 :

Signature : stamp