



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.

### **CONDITION AND PROPOSED TREATMENT**

My ophthalmologist has diagnosed me with dry eye syndrome. Typical symptoms of this condition include burning and (paradoxically) watering and a sensation like something is in the eye. In many cases dry eyes are caused by the body's failure to produce enough tears. Blocking the tear drainage system with punctal or intracanalicular (tear duct) plugs may improve symptoms by keeping more tears in the eye. Severe cases of dry eye may lead to infection and in rare cases, blindness or loss of the eye.

### **ALTERNATIVES**

1. Artificial tears or ointment – Lubrication increases moisture on the surface of the eye. Depending on severity, these over-the-counter drops and ointments may be applied several times daily for maximal comfort
2. Restasis – Used twice daily, this prescription eye drop increases production of the body's own tears.
3. Surgical tear drainage closure – The punctum and canaliculus may be surgically occluded by thermal cautery (heat) or ligation (suture closure). These methods should be considered permanent.
4. No Treatment – I may choose to do nothing and tolerate the symptoms of my dry eye condition.

### **RISKS**

1. Infection - The punctal plug is a foreign material and may be associated with infection around the plug. Infections can be treated with antibiotics and removal of the plug.
2. Excessive Tearing – In some cases, plugs may cause an overflow of tears. Your doctor may decide to remove the plugs in this situation.
3. Irritation – The exposed end of the punctal plug may cause irritation and need to be replaced with a different size plug or removed.
4. Loss of the Plug – The punctal plug may fall out or need to be replaced.
5. Retention of plug in or permanent scarring of the tear duct – Although rare, plugs may become lodged in the tear drainage pathway (canaliculus) or cause scarring. Surgery may be necessary to re-establish tear drainage

### **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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**CONSENT FOR TREATMENT**

By signing below, I acknowledge that I have read and understand the above and have had the opportunity to discuss this information with my doctor to my satisfaction. I consent to the insertion of punctal plugs in the (PLEASE CIRCLE):

**RIGHT** lower upper **LEFT** lower upper eyelid(s)

**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