



INFORMED CONSENT FOR IMPLANTABLE CONTACT LENS

IMPORTANT: READ EVERY WORD!

INTRODUCTION

THIS INFORMATION IS GIVEN TO YOU SO THAT YOU CAN MAKE AN INFORMED DECISION ABOUT HAVING EYE SURGERY. TAKE AS MUCH TIME AS YOU WISH TO MAKE YOUR DECISION ABOUT SIGNING THIS INFORMED CONSENT. YOU HAVE THE RIGHT TO ASK QUESTIONS ABOUT ANY PROCEDURE BEFORE AGREEING TO HAVE THE OPERATION.

AFTER YOUR DOCTOR HAS TOLD YOU THAT YOU ARE A CANDIDATE FOR IMPLANTABLE CONTACT LENS, YOU AND YOUR DOCTOR ARE THE ONLY ONES WHO CAN DETERMINE IF OR WHEN YOU SHOULD HAVE SURGERY—BASED ON YOUR OWN VISUAL NEEDS AND MEDICAL CONSIDERATIONS.

I MAY DECIDE NOT TO HAVE AN IMPLANTABLE CONTACT LENS AT ALL. OTHER POSSIBILITIES OF VISION CORRECTION HAVE BEEN EXPLAINED TO ME, SUCH AS LASIK, PRK, REFRACTIVE LENSECTOMY, GLASSES AND CONTACT LENSES, ALONG WITH THEIR BENEFITS, RISKS AND COMPLICATIONS.

Patient's Signature _____

CONSENT FOR OPERATION

IN GIVING MY PERMISSION FOR IMPLANTABLE CONTACT LENS SURGERY (IMPLANTATION OF AN ARTIFICIAL PHAKIC INTRAOCULAR LENS WITHIN THE EYE), I DECLARE I UNDERSTAND THE FOLLOWING INFORMATION:

1. THE RESULTS OF SURGERY IN MY CASE CANNOT BE GUARANTEED
2. DURING SURGERY, MY DOCTOR MAY DECIDE NOT TO IMPLANT A PHAKIC INTRAOCULAR LENS IN MY EYE EVEN THOUGH I HAVE GIVEN PRIOR PERMISSION TO DO SO.
3. **SPECIFIC COMPLICATIONS OF LENS IMPLANTATIONS:**
INSERTION OF A PHAKIC INTRAOCULAR LENS MAY INDUCE COMPLICATIONS WHICH OTHERWISE WOULD NOT OCCUR. IN SOME CASES COMPLICATIONS MAY DEVELOP DURING SURGERY FROM IMPLANTING THE LENS (FOR DAYS, WEEKS, OR EVEN YEARS LATER). COMPLICATIONS MAY INCLUDE CATARACT FORMATION, LOSS OF CORNEAL CLARITY, INFECTION, UVEITIS, IRIS ATROPHY, GLAUCOMA, BLEEDING IN THE EYE, INABILITY TO DILATE THE PUPIL, GLARE, DISTORTION, DOUBLE VISION, DISLOCATION OF THE LENS, RETINAL DETACHMENT AND INCREASED/DECREASED INTRAOCULAR PRESSURE (FLUID PRESSURE INSIDE THE EYE).

PATIENT'S INITIAL _____

PAGE 1 OF 3

4. AT SOME FUTURE TIME, THE LENS IMPLANTED IN MY EYE MAY HAVE TO BE REPOSITIONED OR REMOVED SURGICALLY.
5. LASIK SURGERY MAY BE REQUIRED TO FINE TUNE MY VISION. LASIK MAY EVEN BE ADVISED AS A SECONDARY PROCEDURE PER-OPERATIVELY. THE PRICE OF LASIK IS NOT INCLUDED IN THE PRICE OF THE IMPLANTABLE CONTACT LENS.

COMPLICATIONS OF SURGERY IN GENERAL: AS WITH ALL TYPES OF SURGERY, THERE IS THE POSSIBILITY OF OTHER COMPLICATIONS DUE TO ANESTHESIA, DRUG REACTIONS, OR OTHER FACTORS WHICH MAY INVOLVE OTHER PARTS OF MY BODY, INCLUDING A POSSIBILITY OF BRAIN DAMAGE OR EVEN DEATH. SINCE IT IS IMPOSSIBLE TO STATE EVERY COMPLICATION THAT MAY OCCUR AS A RESULT OF SURGERY, THE LIST OF COMPLICATIONS IN THIS FORM IS INCOMPLETE. THE BASIC PROCEDURES OF IMPLANTABLE CONTACT LENS, ITS RISKS, POSSIBLE COMPLICATIONS, THE ADVANTAGES AND DISADVANTAGES OF ALTERNATIVE TREATMENTS HAVE BEEN EXPLAINED TO ME. ALTHOUGH IT IS IMPOSSIBLE FOR THE DOCTOR TO INFORM ME OF EVERY POSSIBLE COMPLICATION THAT MAY OCCUR, ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

I AM STATING I HAVE READ THIS INFORMED CONSENT (OR IT HAS BEEN READ TO ME) AND I FULLY UNDERSTAND IT AND THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM THE SURGERY. NO WARRANTY OR GUARANTEE HAS BEEN GIVEN AS TO THE RESULTS THEREOF. NO GUARANTEE OF 20/20 VISION HAS BEEN GUARANTEED OR IMPLIED.

1. I WISH TO HAVE AN IMPLANTABLE CONTACT LENS ON MY:
 - RIGHT EYE
 - LEFT EYE
 - BOTH EYES

Patient's Signature _____

Witness Signature _____

REFRACTIVE KERATOTOMY WITH CORNEAL OR LIMBAL RELAXING INCISIONS

1. REFRACTIVE KERATOTOMY INVOLVES PLACING CUTS ON THE SURFACE OF MY EYE. THESE CUTS FLATTEN STEEP AREAS OF MY CORNEA SO THAT MY VISION MAY BE IMPROVED, EVEN POSSIBLY TO THE POINT OF NOT WEARING GLASSES.
2. DURING SURGERY, MY DOCTOR MAY DECIDE TO PERFORM REFRACTIVE KERATOTOMY ON MY EYE, WHICH HE MAY DEEM ADVISEABLE FOR MY WELL BEING.

PATIENT'S INITIAL _____

PAGE 2 OF 3

COMPLICATIONS OF REFRACTIVE KERATOTOMY

1. AS A RESULT OF SURGERY, IT IS POSSIBLE MY VISION COULD BE MADE WORSE DUE TO DISTORTION FROM IRREGULAR HEALING OF THE CORNEAL AND/OR LIMBAL INCISIONS. I UNDERSTAND THE WEARING OF A CONTACT LENS, IN THIS INSTANCE, MAY NOT AFFECT USEFUL VISION.
2. I UNDERSTAND THERE IS A 1-250,000 CHANCE OF VISUAL LOSS DUE TO INFECTION THAT IS UNCONTROLLED BY ANTIBIOTICS OR ANY OTHER MEANS.
3. IT IS POSSIBLE THAT DESIRED RESULTS MAY NOT BE OBTAINED INITIALLY, AND FURTHER SURGERY MAY BE NECESSARY AT A LATER DATE.

Patient's Signature _____

THE BASIC PROCEDURES OF REFRACTIVE KERATOTOMY SURGERY, ITS ADVANTAGES, DISADVANTAGES AND RISKS HAVE BEEN EXPLAINED TO ME. I AM STATING I HAVE READ THIS INFORMED CONSENT (OR IT HAS BEEN READ TO ME). I FULLY UNDERSTAND THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM SURGERY. NO WARRANTY OR GUARANTEE HAS BEEN GIVEN AS TO THE RESULTS THEREOF.

Patient's Signature _____

I AUTHORIZE AND DIRECT _____ M.D., MY SURGEON AND/OR ASSOCIATES OR ASSISTANTS OF HIS CHOICE TO IMPLANT AN IMPLANTABLE CONTACT LENS (ICL) WITH CORNEAL RELAXING INCISIONS (IF INDICATED) ON ME, USING MONITORED ANESTHESIA CARE/IV SEDATION WITH TOPICAL/LOCAL ANESTHETICS AND/OR ANY THERAPEUTIC PROCEDURE WHICH HE MAY DEEM ADVISABLE FOR MY WELL BEING, WHETHER OR NOT ARISING FROM PRESENTLY UNFORSEEN CONDITIONS.

PATIENT SIGNATURE _____

PATIENT NAME (PRINTED) _____

STAFF SIGNATURE _____

DOCTOR _____

RIGHT EYE DATE _____

LEFT EYE DATE _____