Orlando Ophthalmology Surgery Center
Authorization for Surgical Procedure

Patient Name_____Surgeon_____

Proposed Procedure: **YAG Laser Peripheral Iridotomy_____eye_____**

Your doctor has suggested that you have a procedure called YAG laser peripheral iridotomy to help your eye drain properly so as to help prevent or treat glaucoma.

1. **Explanation of Procedure:**
   The inside of the human eye contains a "plumbing system", in which fluid is constantly produced toward the back of the eye and drained near the front. Some patients with eyes that are shorter than normal will have a drain that is somewhat narrow or closed off compared to others. If this drainage area, also called "the angle", suddenly closes completely, this may cause a sudden and severe type of glaucoma with pain, redness of the eye, nausea, blurred vision and dangerously elevated pressure inside the eye. Permanent visual impairment is common if treatment is not rendered quickly. This condition, known as "acute angle-closure glaucoma", can often be prevented by focusing a laser beam on the iris (colored part of the eye) and making a small hole in it. This allows fluid made in the eye to have better access to the drain, preventing a sudden rise in pressure. There is minimal, if any discomfort from the procedure, which takes less than 5 minutes to perform.

2. **Possible Complications:**
   Complications from a laser iridotomy are uncommon, however they can occur. The most common complications are failure to achieve the intended result, inflammation, bleeding, transient elevation or continued elevation of pressure within the eye, glaucoma, damage to the cornea or lens, glare, cataract formation, and swelling in the central part of the retina causing blurred vision. Severe complications are rare, and although they may be treatable, they may result in partial or total loss of vision. Occasionally, several laser treatments over a period of a few weeks may be necessary to form an adequate hole in the iris to improve eye drainage. Medications to lower eye pressure may still be necessary post-operatively, either shortly after surgery or several years later.

3. **Alternatives Treatments:**
   Continual daily use of certain eye drops might also prevent an attack of sudden angle-closure. A main alternative to the laser treatment is to have no procedure at all.

4. My doctor has explained the risks and benefits of the procedure to my satisfaction, and all my questions regarding the procedure have been answered. I acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment. I understand that since it is impossible to state every complication that may occur as a result of this procedure, the list of complications stated in this form is not complete.

5. I hereby authorize the above named surgeon and whomever he/she may designate to perform upon me (the above named patient) the above specified procedure and if any unforeseen condition arises in the course of the procedure which in the judgment of the attending physician or the surgeon in charge calls for

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(Initials)

procedure(s) or operation(s) in addition to or different from those now contemplated, I further request and authorize him or her to do whatever he/she deems advisable.

6. If any unforeseen medical condition should arise while I am at the Surgery Center, I hereby authorize treatment including, but not limited to evaluation, consultation and transfer to another level of care.

7. I authorize the release of any medical information necessary to process my insurance claim.

8. I authorize the payment of medical benefits to Orlando Ophthalmology Surgery Center for services described.

I CERTIFY THAT I HAVE READ OR HAVE HAD READ TO ME AND FULLY UNDERSTAND THE ABOVE CONSENT FOR SURGICAL AND/OR DIAGNOSTIC PROCEDURES, THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

Signature of Patient_____Date_____Time _____

When Patient is a minor or incompetent to give consent:
Patient is a minor _____ years of age or is unable to sign because_____

Signature of person authorized to give consent for Patient: _____

Relationship to Patient _____Date_____ Time _____

WITNESS: _____Date_____ Time _____

Translator/Interpreter (Print Name, Address and Phone Number) _____

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PHYSICIAN'S AFFIRMATION OF CONSENT

I certify that I have informed the patient of his/her representative of the nature of this procedure, alternative methods thereto, including non-treatment, and the risks associated therewith.

Physician's Signature _____M.D./D.O. Date _____

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(Initials)