Orlando Ophthalmology Surgery Center
Authorization for Surgical Procedure

Patient Name_________________________________ Surgeon________________________________

Proposed Procedure: **Vitrectomy___________ eye_____________________________________**

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1. Your doctor has determined that you have a disease of the eye that requires a vitrectomy, a procedure in which the vitreous gel that fills most of the eye is removed. In addition to the removal of the vitreous, he/she will remove all foreign substances in the vitreous such as blood, membranes and other opaque material so that there will be a clear pathway from the front of your eye back to the retina, enabling you to have better vision.

2. **COMPLICATIONS OF VITRECTOMY OPERATION:**
   Complications from vitrectomy can occur. Damage to the cornea (window of the eye), the iris (colored part of the eye), and the retina (the sensitive part of the eye) has been known to occur from vitrectomy. A cataract may develop during or after the operation and may require removal at the time of surgery or at a later date. You would then most likely need to use a corrective glass or contact lens to compensate for this. In some cases there may be no useful vision in that eye.

   In addition, during surgery, the retina may be found to be detached or may tear during the operation. In either case, it is necessary to try to reattach the retina during the same operation, if possible. In some cases, it may be necessary at a later date to try to reattach the retina. Glaucoma (an elevation in the pressure of the eye) may result, requiring short-term or long-term treatment or additional surgery in the future. Chronic pain or double vision may occur. Blurred or distorted vision may also occur, requiring a change in your glasses. Other risks include infection within the eye, hemorrhage, blood clots, worsening of already present eye disease, return of the eye disease requiring future surgery and even loss of the eye.

3. **LASER PHOTOCOAGULATION**
   Laser photocoagulation is a procedure in which the doctor aims a very powerful and accurate beam of light (laser beam) at the abnormal parts of the eye. An Argon laser may be used in conjunction with your vitrectomy procedure to seal blood vessels in the back of the eye to stop bleeding or to assist in reattaching a detached retina.

   Complications from laser photocoagulation are uncommon, but they do occur. It is possible that you will be worse after the procedure than you are right now. Damage to the cornea, iris and retina have occurred in rare instances, possibly resulting in worsening of vision, blindness, and disease of the eye requiring prolonged treatment. It is also possible that whatever condition is present in the eye before the procedure will come back after the procedure is performed. It may be necessary to repeat the procedure on one or more occasions at a later date.

4. **ADDITIONAL UNFORSEEN CONDITIONS OF SURGERY IN GENERAL:**
   Other complications, though uncommon, due to surgery in general, may occur. These include, but are not limited to allergic reactions to medications or other substances used during your procedure, adverse side effects of drugs, loss of bodily function or life as well as transmission of infectious disease, including hepatitis and Acquired Immune Deficiency Syndrome (AIDS).

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(Initials)

5. **COMPLICATIONS OF ANESTHESIA**:
   Although uncommon, complications due to anesthesia can occur. Possible complications of local anesthesia injections around the eye include perforation of the eyeball, bleeding, destruction of the optic nerve, interference with circulation of the retina, possible drooping of the eyelid, double vision, respiratory depression, or hypotension.

   Possible complications of general anesthesia include heart or other organ damage and loss of bodily function or life.

6. **ALTERNATIVES TO SURGERY:**
   No surgery is without risks. The alternative is to observe the eye condition only, allowing the problem to take its natural course.

7. The nature and purpose of the operation and anesthesia, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me by my physician. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

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

9. 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.

10. I consent to the administration of such anesthetics as indicated in the judgment of the Anesthetist, Physicians, and Surgeons in charge of me.

11. I consent to the administration of blood or blood products, medications, and other substances and the use of x-ray and other procedures deemed appropriate by the physician(s) or surgeon(s) in charge of me in the exercise of his or her judgment.

12. I consent to the examination, use or disposal by my physician or surgeon or an appointed physician or surgeon or the Orlando Ophthalmology Surgery Center, of any organs, tissues, fluids, or parts removed from the body.

13. I consent to the taking and publication of any photographs or videotaping in the course of this operation for medical, scientific or educational purposes. Photographs may include appropriate portions of the body, provided no identity by the pictures or by descriptive text accompany them. Video tapes are property of the physician. Photographs will be incorporated in the medical record.

14. I consent to the admittance of observers in the operating room for the purpose of advancing medical education.

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

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(Initials)

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

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 or 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. Date _________________

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(Initials)