Orlando Ophthalmology Surgery Center
Authorization for Surgical Procedure

Patient Name_____ Surgeon_____

Proposed Procedure: Pterygium Removal eye with possible graft

---

Your doctor has determined that you have a pterygium, a fleshy growth coming from the conjunctiva (a membrane covering the white of the eye) and invading the cornea (clear window of the eye). The pterygium may be small in size and cause no problem, or grow large enough to cover the cornea and interfere with your vision. It usually develops in the inner corner of the eye.

The exact cause of a pterygium is not well understood. The condition occurs more often in people who spend a lot of time outdoors, especially in sunny climates. Long term exposure to sunlight, ultraviolet rays, and dusty conditions may contribute to the cause.

When the pterygium becomes red and irritated, threatens one's eye sight, and/or appears unsightly, it can be removed surgically.

- **Conjunctival Grafts or Flaps**
  A conjunctival graft or flap may be done at the time of surgery to reduce the chance of the pterygium growing back. This graft or flap is usually harvested from a separate site on the same eye. The. flap or graft is then closed with fine sutures. These sutures may incite inflammation and may need to be removed in the office later.

- **Allografts**
  These are FDA approved tissue grafts such as Alloderm or Amniograft, harvested from human tissue that has been specially processed to reduce any risk of disease transmission. Your doctor may feel that it is necessary to use one of these grafts instead of your own conjunctival tissue. Rejection or post-operative inflammation and scarring may occur in rare instances, requiring removal, replacement or other repairs. Although the risk of disease transmission such as hepatitis or HIV from these tissue grafts is exceedingly rare, it remains a theoretical possibility.

- **Antimetabolites**
  During the procedure, your doctor may also use a chemical called Mitomycin-C or 5-Fluorouracil to prevent scar tissue formation or re-growth of tissue following the procedure. The risks of using Mitomycin-C and 5-Fluorouracil include: corneal staining and superficial surface changes on the cornea, conjunctival thinning with leaks that may require further surgery, and increased risk of infection.

_____
(Initials)

1. **ALTERNATIVE TREATMENTS:**
Observation and over-the-counter artificial tears or bland ointment may be ordered to lubricate the surface of the eye. Anti-inflammatory drops and/or ointment may be prescribed for redness and irritation. In addition, the use of ultraviolet-blocking sunglasses is advisable to reduce the exposure to further ultraviolet rays.

2. **COMPLICATIONS OF LOCAL ANESTHESIA INJECTION**:
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, loss of vision, respiratory depression, or hypotension.

3. **COMPLICATIONS OF SURGERY TO REMOVE A PTERYGIUM:**
Complications from pterygium removal are rare, but can occur. Possible complications are infection, reaction to suture material used, distortion and/or reduction of central vision, redness of the eye, irritation, graft dehiscence (breaking away), chronic scarring of the conjunctiva and cornea, corneal perforation, corneal ulceration, thinning or perforation of the sclera or "white of the eye", loss of sight, vitreous hemorrhage (bleeding into the clear "jelly" in the posterior portion of the eye), retinal detachment, loss of the eye, and double vision due to scarring of muscles controlling eye movement.

4. **ADDITIONAL UNFORSEEN CONDITIONS OF SURGERY IN GENERAL:**
Just as there are benefits to the procedure(s), I also understand that medical and surgical procedures involve risks. These risks include, but are not limited to allergic reactions, bleeding, blood clots, infections, adverse side effects of drugs, or even loss of bodily function or life as well as the transmission of infectious disease, including hepatitis and Acquired Immune Deficiency Syndrome (AIDS).

5. The nature and purpose of the operation and anesthesia, possible alternative methods of treatment, the risk(s) involved, and the possibility of complications listed above 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.

6. 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.

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

8. 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.

9. 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.

_____
(Initials)

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

11. 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.

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

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

14. I authorize 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) _____

_____

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. /D.O. Date _____

_____
(Initials)