Orlando Ophthalmology Surgery Center
Authorization for Surgical Procedure

Patient Name___________________________________Surgeon___________________________________

Proposed Procedure: **YAG Laser Posterior Capsulotomy____________ eye**

1. **EXPLANATION OF PROCEDURE:**
When a cataract is removed during surgery, the thin membrane that forms the back of the lens is left behind. This "posterior capsule" remains in the eye and holds the lens implant (the artificial lens) in place. In 30-50% of patients who have had cataract surgery, the posterior capsule will eventually become hazy and white, leading to glare problems and a gradual reduction in vision.

   This condition, known as "opacification of the posterior lens capsule," can be treated by focusing a laser beam on the capsule. A YAG laser is used. The laser actually opens the center of the membrane, allowing vision to be clear again. There is no discomfort from the procedure, as the membrane has no nerves or blood vessels. The procedure takes less than two (2) minutes to perform, however your doctor may order dilating drops placed in the eye on which you are having the procedure 15-30 minutes prior to the procedure.

2. **POSSIBLE COMPLICATIONS:**
As with any procedure, the possibility of complications does exist. Complications from a YAG laser capsulotomy are uncommon. These include adverse reactions to eye drops used before and after the procedure, failure to achieve the intended result, inflammation, bleeding, elevated pressure within the eye, glaucoma, damage to the cornea or lens implant, floaters, retinal tears or detachments, 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. If previous retinal disease is present, but not diagnosed because of a poor view, visual acuity may not improve to expected levels.

3. I understand that there are no other accepted medical or surgical techniques to improve opacification of the posterior lens capsule. I understand that the main alternative to surgery in this case is to have no surgery. 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 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.

4. 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 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.

5. 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.

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(Initials)

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

7. 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) ____________________________________

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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)