Orlando Ophthalmology Surgery Center
Authorization for Surgical Procedure
Cataract Operation and/or Implantation of Intraocular Lens

Patient Name_____ Surgeon_____

Proposed Procedure: **Cataract extraction with intraocular lens implant_____ eye**

Your doctor has told you that you have a cataract, an opacity or cloudiness of the crystalline lens of the eye, which may prevent a clear image from forming on the retina. Cataracts may be congenital or caused by trauma, disease or age. You and your doctor are the only ones who can determine if or when you should have a cataract operation based on your own visual needs and medical considerations.

1. **ALTERNATIVE TREATMENTS:**
   There are three methods of restoring useful vision as a result of the operation:

   Intraocular Lens: In the United States, an intraocular lens is by far the most common form of restoring vision from cataract surgery. This is a small artificial lens, usually made of plastic, silicone or acrylic material, surgically and permanently placed inside the eye. Objects are seen at their normal size. Conventional eyeglasses (not cataract spectacles) may be required in addition to an intraocular lens for best vision.

   Spectacles (glasses): Cataract spectacles required to correct your vision are usually thicker and heavier than conventional eyeglasses. Cataract spectacles increase the size of objects by about 25%. Clear vision is obtained through the central part of cataract spectacles, which means you must learn to turn your head to see clearly on either side. Cataract spectacles usually cannot be used if a cataract is only in one eye (and the other is normal) because they may cause double vision.

   Contact Lens: A hard or soft contact lens, placed on the outside of your cornea each day, increases the apparent size of objects only about 8%. Handling of a contact lens is difficult for some individuals. Most lenses must be inserted and removed daily and not everyone can tolerate them. For near tasks, reading glasses may be required in addition to the contact lenses.

2. **COMPLICATIONS OF LOCAL ANESTHESIA INJECTION**:
   Complications of local anesthesia injections around the eye include perforation of the eyeball; bleeding behind the eye; destruction of the optic nerve; interference with circulation of the retina; possible drooping of the eyelid; double vision; permanent loss of vision; respiratory depression or arrest; hypotension; and in rare cases, coma and death.

3. **COMPLICATIONS OF SURGERY TO REMOVE A CATARACT:**
   As a result of the surgery, it is possible that my vision could be made worse. In some cases, complications may occur weeks, months or even years later. Complications may include loss of vision; blindness or loss of my eye; hemorrhage (bleeding); perforation of the eye; loss of corneal clarity; retained pieces of cataract in the eye; infection, high eye pressure; detachment of the retina; uncomfortable or painful eye; droopy eyelid; and/or double vision; displacement of the lens or portions (fragments) of the lens; injury to the cornea; iris, sclera, conjunctivae, pupil function or other parts of the eye and nearby structures, from anesthesia or the operation itself. Sometimes pieces of the lens that cannot be removed and the vitreous gel can become displaced.

In some cases additional sutures to support the IOL or wound, or other additional surgery may be needed at the time of your procedure or at a later time.

4. **SPECIFIC COMPLICATIONS OF LENS IMPLANTATION**:
Insertion of an intraocular lens may induce complications which otherwise might not occur. In some cases, complications may develop during surgery from implanting the lens days, weeks, months, or even years later. Complications may include loss of corneal clarity; infection; uveitis; iris atrophy; glaucoma; bleeding in the eye; inability to dilate the pupil; trouble driving at night; increased night glare and/or halos; double or ghost images; impaired depth perception; decreased contrast; blurry vision; dislocation of the lens and retinal detachment. In rare instances, lens power measurements may significantly vary resulting in the need for corrective lenses or surgical replacement of the intraocular lens.

5 At the time of surgery, my doctor may decide not to implant an intraocular lens in my eye even though I may have given prior permission to do so.

6. The results of surgery in my case cannot be guaranteed. Additional treatment and/or surgery may be necessary. I may need laser surgery to correct clouding of vision. At some future time, the lens implanted in my eye may have to be repositioned, removed surgically, or exchanged for another lens implant.

7. I understand that cataract surgery and the calculations for intraocular implants are not "an exact science." I accept that I might need to wear glasses or contact lenses following surgery to obtain my best vision. There is also the possibility of the need for additional surgeries such as, lens exchange, placement of an additional lens, or refractive laser surgery if I am not satisfied with my vision after cataract removal.

8. **ADDITIONAL UNFORESEEN 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).

9. 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.

10. 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.

11. 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.

12. I consent to the administration of medications, blood or blood products 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.

13. 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.

14. 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.

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

16. I authorize the release of any medical information necessary to process the claim.

17. 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. Date_____