Orlando Ophthalmology Surgery Center

Informed Consent for Ophthalmology Surgery Center

Florida State Law guarantees that you have both the right and obligation to make decisions concerning your healthcare. While your physician can provide the necessary information and advice, as a member of the healthcare team you must enter in the decision-making process. This form has been designed to acknowledge your acceptance of the operative/other procedure(s) recommended by your physician.

1. I, _____, hereby authorize Dr. _____ and/or such associates or assistants as may be selected by said physician to perform the following operative/other procedure(s):

   _____

   _____

2. I understand that during the course of the operative/other procedure, postoperative care, medical treatment, anesthesia or other operative procedure(s), unforeseen conditions may become apparent which require an extension of the original operative/other procedure(s) or different operative/other procedure(s) or additional treatment(s) from that described above. I, therefore, authorize my physician and/or his/her associates to perform such operative/other procedure(s) or additional treatment(s) as they, in the exercise of their professional judgment, deem necessary.

3. I have been informed that there are significant risks such as blood loss, burns, respiratory complications, infection and cardiac complications, which may result from the performance of any operative/other procedure(s) and in some cases, may lead to death or permanent or partial disability. I am aware that the practice of medicine and surgery are not an exact science and I acknowledge that no guarantee has been made to me as to result or cure. I have also discussed with the named physician and/or his/her associate the benefits, risks and complications of this specific operative/other procedure(s).

4. _____ I DO _____ I DO NOT hereby consent to the withdrawal of a blood sample from my body in the event that an employee or physician has had an accidental needle puncture or mucous membrane exposure to my blood or body fluid. I also understand that if an accidental contact does occur, any blood drawn will be tested and handled in a manner that protects my privacy and identity. No results of any tests done on my blood will be released or shown to any unauthorized person without my written authorization.

5. _____ I DO _____ I DO NOT 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. Videos are property of the physician. Photographs will be incorporated into the medical record.

6. For the purpose of advancing medical education, _____ I DO _____ I DO NOT consent to the admittance of students and persons required for technical support to the room in which the procedure is performed.

7. _____I DO _____ DO NOT consent to the examination, use or disposal by my physician or an appointed physician or surgeon of the Orlando Ophthalmology Surgery Center, of any organs, tissues, fluids or part removed from the body.

8. Specific risks for this type of procedure may include but are not limited to:

   Perforation, puncture, laceration, cut, scarring, failure to accomplish intent of surgery, swelling, bruising, moderate pain, sensation changes, tightness, drainage from incision site, excessive bleeding or hematoma, contraction, permanent sensation changes, wound separation, unsightly scarring, collection of fluid, loss of corneal clarity, infection, hemorrhage (bleeding), retinal detachment, glaucoma, double vision, glare or light sensitivity, inflammation inside the eye, inability to implant intraocular lens, pupil abnormalities, dislocation or other problems with intraocular lens requiring surgical repositioning, removal or exchange, eyelid droop, permanent blindness or loss of the eye, asymmetry, dry eye, excessive tearing, double vision, decreased vision, loss of nucleus into the back of the eye, asymmetry, dry eye, excessive tearing, double vision, decreased vision, loss of nucleus into the back of the eye, unsatisfactory outcome, non-scheduled return to surgery, subsequent need to repair and inability to wear contact lenses.

9. I also acknowledge that reasonable acceptable alternative courses of therapy have been discussed with me and the benefits, risks and complications of those alternative courses of therapy.

10. I have had sufficient opportunity to discuss my condition and the planned operative/other procedure(s) with the named physician and/or his/her associate, and all my questions have been answered to my satisfaction. I understand my condition and planned operative/other procedure(s) and I have adequate knowledge upon which to base an Informed Consent. I understand my right to refuse the recommended operative/other procedure(s), the options available to me should I refuse to consent, and the expected consequences of such refusal.

11. I understand the surgery is intended to be performed on an outpatient basis. I consent to my transfer to a hospital or other facility should my physician deem it advisable or necessary.

12. I understand the Surgery Center is not responsible or liable for the loss of or damage to any article of value that I brought to the Center.

    If the patient is unable to sign, complete the following:

    Patient is unable to sign because: _____

_____ _____
Signature of Patient/Guardian/Representative or Legally authorized person/Relationship — Date

_____ _____
Witness to Signature — Date

_____ _____
Physician Signature — Date

_____ _____
Translator/Interpretor/Relationship to Patient — Date