

# Consent to Medical –Surgical Procedure and Administration of Anesthesia

Procedure Scheduled at : **Springview Hospital**      **Health South**      **Other:** \_\_\_\_\_  
Surgeon: *Thomas G. Abell, MD* unless noted otherwise here: \_\_\_\_\_

## Physician's Surgical Procedure Disclosure and Patients Consent

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure so that you may make the decision whether or not to undergo the procedures after knowing the risks involved and any treatment alternatives available to you. This information is not meant to alarm you; it is an effort to make you better informed so that you may give or withhold your consent to the procedure. If you do not understand any of the information provided, ask your physician to explain it.

**1. DIAGNOSIS:** I (we) \_\_\_\_\_ voluntarily request my physician, Thomas G. Abell, M.D., and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my CONDITION and perform procedure(s) **PHACOEMULSIFICATION CATARACT EXTRACTION WITH INTRA-OCULAR LENS IMPLANTATION**. This procedure, including, preoperative preparation, lab work (if needed), eye drop use/instillation, postoperative care, has been explained and reviewed with me.

**2. PROCEDURE(S):** I (we) understand that the following surgical procedure or procedures are planned for me on or about **RIGHT EYE** \_\_\_\_\_ **LEFT EYE** \_\_\_\_\_. I voluntarily consent to and authorize this (these) PROCEDURE(S) because it :

### **(PLEASE HAVE PT INITIAL NEXT TO THEIR SELECTION)**

- \_\_\_\_\_ Interferes with my ability to maintain independence or perform my job
- \_\_\_\_\_ Interferes with staging / treatment of diabetic retinopathy and/or glaucoma
- \_\_\_\_\_ Interferes with my ability to everyday activities including bathing, housework, dressing, walking, preparing meals, using telephone, preparing meals, using toilet,
- \_\_\_\_\_ Limits my ability to DRIVE or SEE in day time and/or night time and/or bright light settings
- \_\_\_\_\_ Limits my abilities to see medications
- \_\_\_\_\_ Limits my participation in hobbies and other activities such as reading, sewing, Internet use or watching television

**3. MATERIAL RISKS:** No guarantee or assurance has been given by anyone as to the results that maybe obtained. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks related to the performance of the surgical, medical and/or diagnostic procedure planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins or lungs, hemorrhage, allergic reactions and even death. I (we) also realize that the following additional RISKS (the following list is not comprehensive) may occur in connection with this (these) procedure(s):

- RETINAL DETACHMENT
- DEVELOPMENT OF GLAUCOMA (INCREASED PRESSURE IN EYE)
- BLEEDING AND/OR INFECTION INSIDE OR OUTSIDE OF EYE
- RED OR PAINFUL EYE
- PTOSIS (DROOPY EYELID)
- IRREGULAR PUPIL
- SECONDARY CATARACT; Clouding of a posterior membrane requiring laser treatment at a later time.
- LOSS OF DEPTH PERCEPTION, BLURRING OF VISION, DOUBLE VISION, OR BLINDNESS
- LOSS OF EYE
- SWELLING OF LAYER UNDER THE RETINA (CHOROIDAL EFFUSION) or WRINKLING OF RETINA
- CHANGE IN FOCUS, REQUIRING NEW SPECTACLE LENSES (REFRACTIVE CHANGES)
- EARLY OR LATE INCREASE OF PRESSURE IN EYE (GLAUCOMA)
- SWELLING OF THE CENTER OF RETINA (CYSTOID MACULAR EDEMA)
- LOSS OF NIGHT VISION, PERIPHERAL VISION, DISTORTION OF VISION OR BLIND SPOTS
- SWELLING OF THE CORNEA (CORNEAL EDEMA) OR CORNEAL CLOUDING AND NEED A CORNEAL TRANSPLANT.
- LOSS OF LIFE.
- FAILURE TO ACHIEVE INTENT OF SURGERY, NECESSITATING A REOPERATION.

**5. ALTERNATIVE AND PROGNOSIS IF NO TREATMENT:** The alternative is observation. I have been informed of the prognosis if no treatment is provided, as follows: A person who has a cataract and does not have surgery for it will likely have slowly or rapidly progressing further decrease in vision. Cataracts that become very advanced are often more difficult to remove surgically. If a person has cataract surgery without lens implantation they will need to wear a contact lens or spectacles to be able to see well.

**6. ANESTHESIA:** I (we) understand that anesthesia involves additional risks but I (we) request the use of an anesthetic for the relief and protection from pain during the planned and additional procedure(s), if any. I (we) realize the anesthesia may have to be changed without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic, including respiratory problems, drug reaction, paralysis, hypotension, brain damage, or even death (loss of life). Other risks and hazards which may result for the use of general anesthetics range from minor discomfort or injury to the vocal cords, teeth or eyes. I (we) understand other risks and hazards resulting from spinal or epidural anesthetics include headaches and chronic pain. Other complications from anesthesia or anesthetic injections around the eye include, but are not limited to, perforation of eyeball, destruction of optic nerve, interference with circulation of retina.

**8. DISPOSAL OF TISSUE:** I (we) authorize the disposal of any surgically removed tissue or parts resulting from the procedure according to accustomed practice.

**9. RESEARCH AND OTHER PARTIES:** I (we) hereby consent to the taking of photographs or films during the procedure and their use for teaching and research purposes. I further consent to the presence of physicians and/or manufacturer representatives to observe procedures.

**10. CONSENT TO TREATMENT OF UNFORESEEN CONDITIONS:** I (we) understand that my physician may encounter or discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and associated technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

**11. OUTCOME:** I (we) understand that the practice of medicine is not an exact science, and that no warranty or guarantee has been made to me as to result or cure.

**CONSENT:**

I (we) have been given sufficient opportunity to ask questions about my condition, alternative treatments, risks of treatment, the procedures to be used, and the risks and hazards involved. All of my questions have been answered to my satisfaction, and I (we) have sufficient information to give this informed consent. I hereby consent to the above-described procedure. I (we) acknowledge a copy of this form has been given to me. I (we) certify that this form has been fully explained to me (us), and that I have read it, or have had it read to me (us), that the blank spaces have been filled in and that I (we) understand its contents.

**X** \_\_\_\_\_

Date: \_\_\_\_\_

Patient or Legally Responsible Person

Time: \_\_\_\_\_ (A.M./P.M.)

\_\_\_\_\_  
Signature of Witness/Staff (Include Position / Title)

\_\_\_\_\_  
Date

To Be Completed By Physician After Patient Consent Completed:

I certify that the procedure(s) described above, including the risks, possible complications, anticipated results, alternative treatment options, including non-treatment, have been explained by me and my representative (noted above) to the patient or his or her legal representative before the patient or his/her legal representative consented.

\_\_\_\_\_  
(Treating Physician)