LASER

MaculaCare

Informed Consent for Laser Procedures
You have been given information about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

□ Daniel F. Rosberger, M.D., Ph.D., M.P.H. □ Nneka O. Brooks, M.D.

Condition: The doctor above has explained to me that the following condition(s) exist in my case:

□ **Open Angle Glaucoma**
□ **Retinal Tear/Hole/Detachment**
□ **Macular Edema**
□ **Proliferative Retinopathy**
□ **Narrow Angle Glaucoma**

Proposed Procedure(s): I understand that the procedure(s) proposed for evaluating and treating my condition is/are:

□ **YAG Peripheral Iridotomy**
A procedure to treat and/or prevent Angle Closure Glaucoma
□ **Argon Laser Trabeculoplasty**
A procedure to treat Open Angle Glaucoma
A procedure to treat clinically significant macular edema
□ **Panretinal Photocoagulation**
A procedure to treat new blood vessel growths
□ **Laser Retinopexy**
A procedure to treat retinal holes, tears or detachments

□ **Grid/Focal Laser**

□ OD (right eye) □ OS (left eye)

Risks/Benefits of Proposed Procedure(s):

a. Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness, and even loss of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.

b. I also realize that there are particular risks associated with the procedure(s) proposed for me and that these risks include, but are not limited to: *Pain, Inflammation, Infection, Elevated Intraocular Pressure, Retinal Tears/Holes/Detachments, Loss of Vision, and Loss of Eye*.

Complications; Unforeseen Conditions; Results: I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

Acknowledgments: The available alternatives, some of which include: *no treatment, intra/periocular injections, or incisional surgery*, the potential benefits and risks of the proposed procedure(s), and the likely result without such treatment: *loss of vision*, have been explained to me. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

Consent to Procedure(s) and Treatment: Having read this form and talked with the physicians, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above (including the administration of blood and disposal of tissue) by my physician and/or his/her associates assisted by hospital personnel and other trained persons as well as the presence of observers.

Patient or Guardian (Print) _____

Signature _____ Date _____

Surgeon _____ Date _____