Hartford Hospital
A Hartford HealthCare Partner

6816

Authorization for Cataract Surgery with Intraocular Lens Implant

Patient's Name: _____

I hereby authorize Dr._____ to perform the following surgery:

Cataract Surgery with Intraocular Lens Implant ❒ Right Eye ❒ Left Eye

__ _____ ❒ Right Eye ❒ Left Eye

I understand that there may be unforeseen circumstances that are encountered while performing the above listed surgery that require the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed surgery: (i) the nature and purpose of the proposed surgery/procedure/treatment; (ii) the foreseeable risks and consequences of the proposed surgery/procedure/treatment, including the risk that the proposed surgery/procedure/treatment may not achieve the desired objective; (iii), and the alternatives to the proposed surgery/procedure/treatment and the associated risks and benefits to such alternatives.

I realize that common risks to surgical procedures include, but are not limited to infection, blood clots, hemorrhage, allergic reactions, nerve injury, vascular injury and even death.

Specifically, in obtaining my informed consent to the surgery, I have been informed of the following reasonably foreseeable risks:

- Loss of eye
- Inflammation or infection
- Corneal clarity
- Foreign body sensation
- Irregular or dilated pupil
- Droopy eyelid
- Total loss of vision
- Clouding of the tissue behind the implant
- Displacement or dislocation of the intraocular lens
- Swelling of the retina
- Increase in eye pressure
- Night time glare
- Vision could be worse
- Need for glasses or contact lenses
- Retained particles of the cataract
- Detachment of the retina
- Light sensitivity
- Double vision
- Need for more surgery

_____Patient initial

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I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed treatment and/or special procedure, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed surgery/procedure/treatment.

I agree to the use of anesthesia and/or sedation/analgesia as required, and if applicable, the disposal of any tissue removed. In some instances introduction of local anesthesia is accomplished by introducing a needle or cannula into the orbit of the eye in order to make the eye insensitive to the operative procedures. The risks of this procedure, although rare can be serious and include injury to the eye itself and the muscles surrounding the eye. Such injuries can lead to visual impairment or total loss of vision. Alternatives to periorbital injection, including sedation in combination with eye drops or numbing gel have been discussed.

I also authorize the Hospital and the above-named physician(s) to photograph, video and /or use any other mediums which result in the permanent documentation of my image for medical, scientific or educational purposes, provided my identity is not revealed by them. I agree that any photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the Hospital so long as the manner of disposition shall be permanent destruction.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

_____M. D. Signed: _____
(Patient or legally authorized representative)

Date: _____ Time: _____ Date: _____ Time: _____

Interpreter responsible for explaining procedures and special treatment:

_____ Date: _____ Time: _____
(Interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [□] BECAUSE:

_____

_____ Date: _____Time:_____
MD

_____ Date: _____Time:_____
Witness