BLOOMINGTON EYE INSTITUTE / GAILEY EYE SURGERY–DECATUR

SURGICAL CONSENT - ACKNOWLEDGEMENT OF INFORMED CONSENT TO OPERATION OR PROCEDURE

Name: _____

1. I hereby request and authorize Dr. _____, and such assistants he/she might select, to treat the condition(s) which appear indicated by the diagnostic studies already performed. The procedure to treat my condition is _____
   _____
   _____

   Other:
   - ☐ **Select laser trabeculoplasty** for open angle glaucoma of **right / left eye:** ☐ Nasal ☐ Temporal ☐ Superior ☐ Inferior ☐ 360°
   - ☐ **Nd YAG laser** to perform a capsulotomy of **right / left eye**. ☐ **Peripheral iridotomy** by YAG laser of **right / left eye.**
   - ☐ **YAG laser severing of vitreous strands** for treatment of floaters of **right / left eye**
   - ☐ **Argon Laser** ☐ Focal ☐ Retinopexy ☐ pan-retinal photocoagulation for **right / left eye.**
2. My doctor has explained to my satisfaction:
   a. The diagnosis of my condition, the procedure(s) or operation(s) to be performed, and the expected outcomes.
   b. Possible benefits: Qualitative visual acuity improvement.
   c. The risks reasonably anticipated by undergoing this procedure, or operation, including the possible consequences and complications.
   d. The risks reasonably anticipated by *not* undergoing this procedure, or operation, including the possible consequences and complications.
   e. Any reasonable alternatives to this method of treatment, and that the choice to undergo or not undergo the procedure, or operation, is mine alone.
3. I understand my doctor's explanation is not exhaustive, but he has given me the chance to ask questions, and I have no further questions at this time. I understand that I can ask more questions at any time.
4. I am aware that during the course of the authorized procedure unexpected conditions may be revealed that require an extension of the authorized procedure or performance of a procedure different than stated in paragraph #1. I, therefore, authorize the above named physician and selected assistant(s) to perform such surgical and/or medical procedures as necessary in his/her professional judgment. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure(s).

Anesthesia:

5. Where anesthesia services may be required as part of this operation or procedure, I have been advised and acknowledge that I am aware that there are risks and complications involved in the administration of anesthesia. I consent to the administration of anesthesia and/or sedation and any invasive monitoring procedure, if required, to be applied by or under the direction and supervision of my physician and/or Anesthesia Pain Services, LLC.

Disposal of Tissue:

6. Any organs, tissues, or foreign objects that may be removed during the operation may be examined, disposed of, or retained for medical purposes in accordance with accustomed practice.

Observers/Photographs:

7. For purposes of advancing scientific knowledge or medical education, and at the discretion of my doctor(s), I give my permission for the following:
   a. The photographing or videotaping of the procedure being performed upon me, as long as my identity is not revealed in any way.
   b. The admittance of observers to the operating room to view the procedure.
   ☐ I **do not** consent to photograph/videotaping of the procedure or observers.

Blood Testing:

8. The drawing of any blood specimen from me for the purposes of confirmation of possible bloodborne pathogens, in the event of an exposure incident to any member of the staff who is assisting with my care.

Emergency Treatment/Advance Directive Waiver:

9. I understand that the Policy at Bloomington Eye Institute/Gailey Eye Surgery-Decatur is to provide immediate resuscitative emergency care and basic life support for any medical emergency. I further understand that BEI/GESD is an Ambulatory Facility and does not wish to withhold life support measures, if a medical emergency should arise, but will transfer me to an acute care hospital. I consent to this "Advance Directive Waiver" as notice that life support may be implemented, in emergency circumstances, during my stay at BEI/GESD.
10. If I have an automatic internal cardiac defibrillator, I understand that it may be disabled during my surgical procedure according to my surgeon.
11. ☐ I understand if I have a documented Latex allergy, appropriate precautions will be taken; however, there may be some products that contain Latex utilized in my care while here at Bloomington Eye Institute/ Gailey Eye Surgery-Decatur.
12. ☐ I understand if I have a documented Iodine/IVP or other associated allergy, I am consenting to a product containing Povidone Iodine to be utilized in the surgical prep prior to my procedure. ☐ I do **not** consent to using a product containing Povidone Iodine in the surgical prep.
13. I understand there may be medication/s and/or supplies used during my procedure that are considered "off label use", and I agree to this use. (List available upon request).

Upon signing this form, I acknowledge that I have read and understand the foregoing authorization. Any changes that the surgery center has made to the above authorization have been initialed by me.

_____ _____
Signature of patient or authorized person Relationship

_____ Date: _____ Time: _____ _____
Witness and Title Witness /Title (If telephone consent)

Physician's Statement: I have fully explained to the above patient or representative of the patient the nature, purpose, alternative methods of treatment and risks involved in the procedure named above, the possibility of complications, and the expected outcomes. I have given no guarantee or assurance of the results that may be obtained from such operation or procedures performed in connection therewith.

Physician's Signature: _____