First Hill
SURGERY CENTER

Cataract Surgery
Consent Form

Patient Name: _____ Date of Birth:_____

Guardian Name (if applicable): _____ Patient ID:_____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision-making process. This form acknowledges your consent to treatment recommended by your physician.

1. MY PROCEDURE

I hereby give consent for Dr._____to perform a **cataract extraction and insertion of an intraocular lens right eye/left eye** upon me. I understand the procedure is to be performed at the First Hill Surgery Center. This has been recommended to me by my physician in order to **improve my vision and/or reduce the risk of glaucoma**.

I understand that the procedure or treatment can be described as follows:
Remove cataract from the eye and insert an intraocular lens.

This procedure may require general anesthesia which will be administered by a qualified anesthesiologist and may include topical drops or injection (local anesthesia).

2. MY BENEFITS:

Some potential benefits of this procedure include:

- Improved visual acuity, decreased glare symptoms, lowered intraocular pressure.

3. MY RISKS:

*I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.*

These could include but may not be limited to the following:

- Infection, which if serious, can lead to partial or complete loss of vision
- Swelling of the retina called macular edema which may lead to limited vision and need further treatment
- Progression of retinopathy in patients with diabetes
- Swelling of the cornea (corneal edema) which may not subside over time and require corneal transplant surgery
- Development of increased intraocular pressure (glaucoma) which may require medical or surgical intervention and could lead to partial or total loss of vision if not controlled

- Detachment of the retina, which can usually be repaired with further surgery, but still carries a risk of partial or total vision loss
- Damage to the retina, eye muscles, or optic from anesthetic block when the needle inadvertently injures the eye or surrounding structures, which may lead to partial or total loss of vision or double vision
- Lid droop (ptosis) can occur due to anesthesia or postoperative use of steroids, which usually resolves but can be permanent and may require further surgery for repair
- Inaccuracy of the intraocular power selection, necessitating further surgical intervention, such as intraocular lens exchange
- Decentration of the intraocular lens can occur which may provide unwanted images or glare
- General risks of anesthesia and surgery, despite the fact that only mild sedation will be used
- Bleeding in the eye, which can lead to partial or total vision loss
- Retained lens fragments, which may cause partion or total vision loss if not surgically removed
- Damage to the iris which may lead to glare or photophobia (intolerance of light)

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

4. MY CONSENT

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatments or procedures.**

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required.**

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition, including no treatment or other procedures or tests. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form and will follow any patient instructions to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **cataract extraction and insertion of an intraocular lens right eye/left eye** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature: _____ Date: _____Time: _____

Patient is unable to consent because_____. I therefore consent for the patient.
Authorized Consenter's Signature: _____Date: _____Time: _____
Printed Name: _____ Relationship to Patient: _____

☐ Mark this box if telephone consent

Witness Name (Printed):_____

Witness Signature: _____ Date: _____Time: _____

By my signature below, I attest to the fact that I explained the procedure to the patient.

Physician Name (Printed): _____

Physician Signature: _____ Date: _____ Time: _____