First Hill
SURGERY CENTER

YAG Laser Capsulotomy
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 my consent for Dr._____to perform a **YAG Capsulotomy of the ☐Left ☐Right Eye** upon me. I understand the procedure is to be performed at The Polyclinic. This has been recommended to me by my physician in order to **remove the cloudy membrane behind the intraocular lens in the eye.**

I understand that the procedure or treatment can be described as follows:
Laser treatment to remove the cloudy membrane behind the implanted intraocular lens.

This procedure will be performed with topical anesthesia (drops) in the affected eye.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Improved visual acuity

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:

- Floaters in the field of vision for some days or weeks afterwards that usually become less noticeable over time
- Swelling of the retina (macular edema) which can cause decreased vision (1-2%) This can usually be treated medically but if left untreated can cause partial vision loss
- Retinal detachment (1-2%) can occur which can lead to partial or total vision loss if not detected and treated early
- Worsening of glaucoma (1-2%) or causing glaucoma (increased pressure) in the eye which can be treated medically or surgically to prevent partial or total vision loss
- Damage to the lens which can cause visual problems and may necessitate intraocular lens removal
- Repeat procedure if membrane regrows

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 treatment 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 related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **YAG Laser Capsulotomy of the Right/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: _____
PRINT NAME

Witness Signature: _____ Date: _____ Time: _____

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

Physician Name: _____
PRINT NAME

Physician Signature: _____ Date: _____ Time: _____