ASTIGMATIC KERATOTOMY (AK)

Astigmatic keratotomy (AK) is a surgical procedure to treat astigmatism that consists of making fine microscopic arcuate (curved) incisions, either singly or as a pair at optical zones of either 6 or 7 mm, or relaxing incisions at the limbus, which is the junction of the clear part of the eye (cornea) with the white (sclera) of the eye. These cuts are made for the purpose of flattening the steepest part of the cornea in an attempt to obtain a more spherical cornea. AK permanently changes the shape of the cornea.

Patient’s Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of astigmatic keratotomy have been discussed with me and may include but are not limited to:

- additional treatment or surgery
- anesthesia complications
- corneal perforation
- corneal ulcer formation
- corneal vascularization
- endophthalmitis
- endothelial cell loss
- epithelial healing defects
- eye more susceptible to impact
- failure to accomplish intent of surgery
- fluctuations in vision during initial stabilization period
- glare or halos, particularly at night
- incapacitating light sensitivity for varying length of time, possibly permanently
- incisional inclusions
- infection
- lose vision or lose best-corrected vision
- no change to vision
- scarring
- vision may not improve or desired results may not be obtained
- worse vision
- eye more susceptible to impact
- failure to accomplish intent of surgery
- fluctuations in vision during initial stabilization period
- glare or halos, particularly at night
- incapacitating light sensitivity for varying length of time, possibly permanently
- incisional inclusions
- infection
- lose vision or lose best-corrected vision
- no change to vision
- scarring
- vision may not improve or desired results may not be obtained
- worse vision

_____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications.

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised whether I should take any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.

_____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

Continued
I authorize and direct ________________, M.D., with associates or assistants of his or her choice, to perform astigmatic keratotomy on ______________________ at ______________________, on the right eye left eye

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time Relationship to Patient

Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the proposed treatment and the risks and consequences of not proceeding, have offered to answer any questions and have fully answered all such questions. I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time

_____ copy given to patient _____ original placed in chart

initial initial

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).