

CAPSULOTOMY

A capsulotomy is a noninvasive laser procedure to eliminate the cloudiness that occasionally interferes with a patient's vision after cataract surgery. In modern cataract surgery, the cataract is removed, but a thin membrane that held the cataract is left in place to hold the implanted artificial lens.

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 therapy, their benefits, material risks and disadvantages have been explained to me.

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

- *additional treatment or surgery*
- *bleeding*
- *discomfort*
- *failure to accomplish intent of surgery*
- *infection*
- *inflammation of the intraocular cavity*
- *intraocular lens damage*
- *intraocular lens dislocation*
- *intraocular pressure rise*
- *loss of vision*
- *no change to vision*
- *retinal detachment*
- *swelling of the macula (central retina)*
- *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 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.

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform capsulotomy on _____ at _____, on the _____
(patient name) (name of facility)

right eye

left eye

Continued

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

initial copy given to patient

initial original placed in chart

SAMPLE